Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 24, 2020	2020_816722_0008	010167-20	Complaint

Licensee/Titulaire de permis

Gem Health Care Group Limited
470 Raglan Street North RENFREW ON K7V 1P5

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

Downsview Long Term Care Centre
3595 Keele Street NORTH YORK ON M3J 1M7

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

COREY GREEN (722)

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): Off-site: June 1-5, 8-12, and 15-16, 2020.

Complaint log #010167-20 was inspected during this inspection related to concerns with resident care in the home, specifically among residents who died during the COVID-19 outbreak and had tested negative for the COVID-19 virus.

This inspection was conducted concurrently with Critical Incident inspection #2020_816722_0009, and Complaint inspection #2020_816722_0010.

PLEASE NOTE: A Written Notification (WN) related to LTCHA, 2007, c.8, s. 6(7), identified in concurrent inspection #2020_816722_0009 (Log #009330-20 and Log #009209-20) was issued in this report. Written Notifications and Compliance Orders (CO) related to LTCHA, 2007, c. 8, s. 6(7) and s. 174.1(3), identified in concurrent inspection #2020_816722_0010 (Log #009393-20), were also issued in this report.

During this inspection, the inspector reviewed resident health records (electronic and hard copy), as well as various administrative records, including relevant policies and procedures, and resident temperature logs.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (ADOC), the Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and resident family members.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #010 collaborated with each other in the implementation of the plan of care.

A complaint was received by the Ministry of Long-Term Care (MLTC) from a physician (MD #104) that assisted the home during the COVID-19 outbreak. The physician identified general concerns with resident care in the home.

Review of resident #010's Advanced Directives form in their chart, as well as the care plan in PointClickCare (PCC), indicated that as of a specified date, the resident had an identified goal of care with specified actions in the event that the resident had a decline in their health status.

Review of the progress notes in PCC for resident #010 indicated that prior to the outbreak of COVID-19 in the home, resident #010's substitute decision maker (SDM) #149 met with the Social Worker (SW) and agreed to change the resident's advanced directive to a specified level. Several days later, MD #150 entered a note that acknowledged the specified goal of care, and identified that the resident's condition had changed significantly. The notes over a specified period identified that the resident's status continued to change. Over a later specified period, the notes indicated that the resident was experiencing specified symptoms, and that their condition continued to change significantly. On a specified date and time, the notes indicated that the resident was deceased.

During this period, there were no notes indicating that a physician was notified or consulted about the resident's change in condition, or appropriate actions. Upon further review of health records, there were no assessments or physician orders identified for resident #010 during a specified period prior to their death. The resident’s orders were reviewed and there were no medications or other palliative care interventions identified to support the resident in end-of-life.

RPN #136 indicated during an interview that they were responsible for resident #010 on two specified dates. They confirmed that the resident's condition had changed significantly and at that time they were nearing end-of-life. The RPN indicated that based on the resident's advanced directives, they would provide specified care and would not contact the doctor with a change in status, which was inconsistent with instructions specified in the advanced directive. The RPN could not recall at the time of the interview if they had notified the physician of the resident’s health status on the two specified dates, and stated that if they had notified the physician, they would have documented it in the progress notes.

ADOC #103 acknowledged during an interview that resident #010 had deteriorated over a specified period of time until their death and, according to the advanced directives set out in their plan of care, a physician should have been notified so that a decision could be made about appropriate actions to take. The ADOC confirmed that there was no indication that a physician was notified of the resident’s condition.

The evidence above shows that the licensee failed to ensure that the registered staff collaborated with the home's physician, as specified in their advanced directive, to determine the appropriate actions to take for resident #010 when their condition changed prior to their death. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #008 and #011 as specified in their plans when their advanced directives were not followed.

(A) The MLTC received a complaint via the Action Line from resident #008’s family member related to concerns with resident care prior to the resident's death and the COVID-19 outbreak in the home.

Resident #008’s Advance Directive form was reviewed, which identified specified actions

that staff were expected to take with a change in the resident's condition and that was signed by substitute decision maker (SDM) #137. At a later specified date, prior to the COVID-19 outbreak in the home, it was revised by MD #147 with verbal consent from the resident's SDM. The resident's care plan was reviewed and at the time of inspection the advanced directive had not been revised to reflect the change noted by MD #147. Also see findings under LTCHA, 2007, s. 6(1)(c) in inspection report #2020_816722_0010.

Review of the progress notes in PCC for resident #008 confirmed that on a specified date, during an identified shift, RN #127 identified that the resident's condition deteriorated, including potential symptoms of COVID-19. A note on the specified date indicated that the physician was informed, and the resident's family member had been notified and was comfortable with the actions taken by the home. There were no notes regarding the resident's status the following day. The next day, a note by RPN #138 indicated that the resident continued to deteriorate, MD #104 was notified, and specified interventions were put in place in the home. A note on the following day indicated that the family had been notified of the resident's declining status. The next day, the resident was deceased, and the notes showed that required actions specified in the advanced directive were not taken.

During an interview with the complainant, they indicated that when the resident deteriorated, actions specified in their advanced directive were not taken by staff in the home. They explained that on a specified date, the home contacted them and reported that resident #008 was not doing well. The complainant indicated that during that call, the nurse indicated that they were considering taking actions as specified in the advanced directive and that resident #008's SDMs had agreed with this action.

Resident #008's SDM #137 was interviewed and stated that on a specified date, they spoke with RN #127 by telephone and were informed that resident #008 was not doing well. The SDM stated that the RN asked them if they wanted to take actions as specified in the advanced directive, and the SDM indicated that they should take the specified action. They indicated that to their knowledge, the specified actions were never taken for resident #008 according to their wishes. They attempted to call the home for two days prior to resident #008's death and were unable to reach anyone. They also attempted to visit the home the day prior to the resident's death, but they were not allowed to enter.

RN #127 was interviewed, and confirmed that on a specified date, during the day shift, the resident had declined and specified interventions were put in place. They indicated that SDM #137 was notified and indicated that they did not want actions taken as

specified in the resident's advanced directives. They indicated that the resident appeared to be doing better later in the day.

RPN #129 was interviewed and acknowledged that they worked on two specified dates prior to resident #008's death, and were assigned to provide care to the resident. They acknowledged that the resident's status had declined and they were aware of the actions that were specified in the resident's advanced directive. The RPN confirmed that they did not notify the doctor or take the actions as specified in the resident's advanced directive, and could not explain why that was the case.

(B) Resident #011 was reviewed as part of the complaint received by MD #104 related to concerns about resident care in the home during the COVID-19 outbreak, and deaths that occurred among residents who had never tested positive for COVID-19.

Review of resident #011's Advanced Directives form in their chart, as well as the care plan in PCC, indicated that as of a specified date, specified actions were required with a change in the resident's status as per their advanced directive.

The progress notes in PCC were reviewed for resident #011, which indicated that for a specified period there was no indication of any health concerns, which was supported by a note entered by MD #147. On a later specified date and time, RPN #129 entered a note that indicated the resident was deteriorating with specified signs and symptoms. The next day, notes by RPN #136 and RPN #142 indicated that the resident continued to decline. At a specified time, RPN #142 indicated that they had received an order from MD #147 for specified treatment; however, there was no indication in the note that the registered staff discussed with the physician the actions required as per the resident's advanced directive. The notes indicated that several hours later on that same day that resident was deceased; there was no indication that specified actions required as per the advanced directive were taken.

SDM #140 was interviewed and indicated that they were never notified that resident #011 was declining. They indicated that they called the home daily for updates and were informed that the resident was doing fine. They indicated that the ADOC contacted them in the morning on a specified date and informed them that the resident was not responding. SDM #140 indicated that they requested to see the resident that day and the ADOC informed them they would call them back. They stated that Social Worker (SW) #146 called them later in the morning on the same date and notified them that the resident was deceased. The SDM further indicated that the SW read the notes to them

and identified that the resident had started declining a week earlier and they did not understand why they were not notified.

RPN #129 was interviewed and acknowledged working on a specified date; they acknowledged that the resident's condition had deteriorated, which had started on the previous shift. They acknowledged that they did not notify the doctor of the resident's condition or take required actions as specified in the resident's advanced directive.

RPN #136 acknowledged during an interview that they worked on specified dates and that the expectation was that when a resident was declining, they follow their advanced directives and notify the doctor. The RPN confirmed that they did not notify the doctor or family of the resident's condition and indicated that they had notified ADOC #103 and the nurse manager, RPN #142, of the resident's declining condition before they went home at the end of their shift.

ADOC #103 confirmed during an interview that residents #008 and #011 both declined over a specified period, and that according to the Advanced Directives in their plans of care, specified actions should have been taken when they deteriorated. Further, they stated that a specified intervention should have been initiated for resident #011 when they were identified in a specified condition. The ADOC further explained that they had been informed by Administrator #101, who no longer worked at the home, that they had received direction from ambulance services to only take specified actions for residents in the home as a last resort. They indicated that they were being discouraged from taking those specified actions, but were unsure where this direction came from.

ADOC #103 acknowledged that residents #008 and #011 did not receive care as set out in their plans of care when their advanced directives were not followed. [s. 6. (7)]

3. The licensee has failed to ensure that care set out in resident #006's plan of care was provided to the resident as specified in the plan.

A report was received from ADOC #103 via the MLTC After Hours InfoLine related to a fall that involved resident #006, where the resident sustained a fall with a specified injury and identified actions were taken.

Review of the progress notes indicated that resident #006 sustained a fall on a specified date and time, a specified injury was identified the following day, and specified action was taken. RPN #142, Nurse Manager, completed the post fall assessment in PCC on

the day of the fall and indicated: "Mild facial grimacing noted while assessing [the resident]. Instructed primary RPN to administer PRN [as needed] analgesic."

Review of the Medication Administration Record (MAR) indicated that the resident had a routine order for specified pain medication, and that a dose had been provided on the date of and prior to the resident's fall. The resident also had Medical Directives in place for pain medication as needed. There was no indication in the MAR that any additional pain medication was administered to resident #006 after the fall and before their routine dose of medication was due.

RPN #142 was interviewed and confirmed that they were working on the date when resident #006 fell. They said they were not assigned to provide care to the resident, but discovered the resident on the floor when they passed the resident's room and heard the bed alarm. The RPN confirmed that the resident appeared to be experiencing pain as a result of the fall based on their facial grimacing, that they asked the RPN responsible for the resident to administer pain medication, and that the resident had a medical directive for additional pain medication as needed. They verified that if an additional pain medication had been administered, it would have been documented on the MAR.

ADOC #103 acknowledged in an interview that the resident, as per their plan of care and existing medical directives, should have been given another dose of pain medication when they sustained their fall and registered staff identified that the resident was experiencing pain. They further stated that if staff were concerned about giving an additional dose of the ordered pain medication, they should have consulted with the physician to get an order for a different pain medication. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 (RD), who is a member of the staff of the home, completed a nutritional assessment for residents #009 and #010 when there was a significant change in their health condition.

A complaint was received by the MLTC from MD #104, who identified general concerns with resident care, including deaths that occurred during the outbreak among residents who had never tested positive for COVID-19.

(A) Review of the progress notes in PCC for resident #009 indicated that during a specified period the resident had a change in their food and fluid intake. The notes indicated that the resident's clinical status declined and the resident died. There were no notes identified which indicated that the resident was referred to or assessed by the RD

at any time during this period.

Review of the Nutrition and Hydration Flow Sheet showed that resident #009 had a change in their food and fluid intake over an identified period of time.

A Nutritional Assessment was reviewed which was completed on a specified date prior to the resident's declining health status, by the Food Services Supervisor #148, which identified that resident #009 was at a specified nutritional risk for several reasons. There were no Nutritional Assessments completed by the RD after the specified date.

PSW #133 confirmed in an interview that resident #009's food and fluid intake had changed leading up to their death. They indicated that they would attempt to provide assistance with feeding as per the resident's plan of care, but that it was not successful. They also confirmed that they notified the registered staff on shift, who were also not successful with providing the required level of assistance.

RPN #109 indicated in an interview that they had been responsible for resident #009’s care, then was off for a specified duration, and returned on a specified date. They indicated that when they left, the resident's food and fluid intake was usual for the resident and when they returned, the resident's intake changed. They confirmed during the interview that the expectation was that residents should be referred to the RD when their food and fluid intake changed and confirmed that resident #009 was not referred to the RD for assessment.

(B) Review of the progress notes showed that resident #010 had a history of a specified level of food and fluid intake. There was an entry on a specified date which indicated that the RD assessed the resident. Notes on most days over a specified period indicated that the resident's food and fluid intake had changed. On a specified date, there was a warning message in the progress notes which identified that resident #010 had a significant change in their weight on a previous specified date. In response to the warning, registered staff indicated that the resident's intake had changed, and that the physician, RD, and family were notified. Over a specified period, the progress notes indicated that the resident’s health status continued to change significantly, with specified signs, symptoms, and interventions. The resident died on a specified date and there were no notes entered by the RD over this specified period of decline.

Review of the Nutrition and Hydration Flow Sheet showed that the resident's food and fluid intake had changed significantly over a specified period of time.

A Nutrition Assessment was completed by RD #131, prior to the resident's declining health status, and identified that resident #010 was at a specified level of nutritional risk. The assessment identified that the resident was ordered a specified nutritional supplement at the time of the assessment, and there were no further revisions to their care plan related to assistance with eating and/or other interventions.

RD #131 indicated during an interview that the expectation in the home was that they assess residents on admission, quarterly and with any significant change in their condition. They confirmed that both residents #009 and #010 had a significant change in their condition over a specified period, both residents had decreased food and fluid intake, and that they never assessed either resident because they did not receive a referral from registered staff. They also confirmed that they were not aware that resident #010 had a significant weight change on the specified date. They indicated that during this time, they were not receiving referrals from registered staff because poor intakes were such a widespread problem among residents in the home during the COVID-19 outbreak, and there was a critical staff shortage. The RD reported that they had sent a notice to all registered staff during this period that they could administer additional nutritional supplements if residents were not eating well.

ADOC #103 acknowledged during an interview that registered staff should have reviewed resident #009 and #010's food and fluid intakes daily, sent a referral to the RD when the residents' condition changed and their food and fluid intakes changed, and the RD should have assessed the resident. The ADOC acknowledged that the RD likely did not receive referrals for residents #009 and #010 during this period because the home was critically short-staffed due to COVID-19, and there were many agency staff in the home. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to carry out every operational or policy directive that applies to the long-term care home.

Under s. 174.1(1) of the LTCHA, 2007, the Minister may issue operational or policy directives respecting long-term care homes where the Minister considers it to be in the public interest to do so.

(A) On March 30, 2020, the Chief Medical Officer of Health (CMOH) re-issued Directive #3 for Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act, 2007, which instructed LTCHs to conduct active screening of all residents, and that any resident with symptoms, including mild respiratory and/or atypical symptoms, must be isolated and tested for COVID-19.

(i) The MLTC received a complaint via the Action Line from resident #008's family member related to concerns with resident care related to COVID-19 leading to their death.

The progress notes in PCC for resident #008 were reviewed for a specified period until their date of death. There was no documentation identified which indicated that a COVID-19 test had been completed for the resident, or results of any COVID-19 tests. The notes indicated that the resident declined over a specified period of time and that the resident developed specified signs and symptoms of infection. RPN #138 entered a note on a specified date and time which indicated that the physician had requested a COVID-19 test to be completed and ADOC #103 was made aware. Resident #008 continued to decline with specified signs, symptoms, and interventions put in place until their death.

A laboratory report was reviewed for resident #008, which indicated that a sample for COVID-19 was collected from the resident on a specified date, as part of the home's routine surveillance testing and prior to the resident developing any signs or symptoms of infection, and the result was reported to the home several days later. There were no

other COVID-19 laboratory reports available for resident #008 after the resident developed possible signs and symptoms of infection.

The complainant indicated in an interview that they were aware the resident had been tested initially for COVID-19, before the resident's condition changed as part of the home's routine testing. They stated that they heard about the COVID-19 outbreak in the home, they were aware nursing staff had been brought in from HRH, and called the home at a later date to ensure that resident #008 was tested again. They were informed by registered staff on the phone that COVID-19 testing of residents was a management decision. On a later date, they spoke with staff #145, and were informed that only symptomatic residents were being tested for COVID-19; but that another registered staff had indicated that all the residents who were positive for COVID-19 were asymptomatic. The family member indicated that to their knowledge, resident #008 was never tested for COVID-19 when their health condition changed. After the resident’s death, family member #144 called the home and spoke with Social Worker #146, who advised them that the resident had not been tested for COVID-19 since the initial test.

RN #127 and RPN #138 both acknowledged in separate interviews that resident #008 had developed respiratory symptoms, and that the resident should have had a COVID-19 test. They both also stated that registered staff on the floor were not responsible for the COVID-19 testing of residents, and that management were responsible for determining who was tested and doing the swabs.

(ii) The MLTC received a complaint from MD #104 about concerns related to resident care and deaths that occurred among residents who had tested negative for COVID-19.

The progress notes in PCC for resident #011 were reviewed, which indicated that the resident had a specified symptom on a specified date. On a later specified date, the resident developed additional symptoms and interventions were initiated. They continued to decline and died the following day.

A laboratory report was reviewed for resident #011, which indicated that a sample for COVID-19 was collected from the resident on a specified date, as part of the home's routine resident testing prior to the outbreak, and the result was reported to the home several days later. There were no other COVID-19 laboratory reports available for resident #011 prior to their death.

RPN #129 and RPN #136 both acknowledged in separate interviews that they had

provided care for resident #011 in the days prior to their death; they indicated that the resident declined quickly and had symptoms of infection. Both indicated that they did not swab the resident for COVID-19, because management of the home decided who should be tested for COVID-19.

ADOC #103 confirmed in an interview that residents #008 and #011 were not tested for COVID-19 when they developed respiratory symptoms. They acknowledged that in early May 2020, there was not a proper plan in place in the home for testing residents for COVID-19, and there was unclear communication with staff about testing symptomatic residents. They further stated that testing was challenging as many of the home's clinical coordinators were off work due to COVID-19.

(B) As of March 30, 2020, Directive #3 directed LTCHs to review resident's advanced directives in preparation for COVID-19. In a complaint to the MLTC, MD #104 also identified concerns with lack of discussions related to goals of care (i.e., advanced directives) for residents in the home.

(i) Review of the Advanced Directive form in resident #009's chart indicated that on a specified date soon after the resident's admission to the home, an advanced directive was put in place which was signed by the physician and resident #009's SDM. There was a notation on the form that the directive was changed on a specified date, several weeks after the COVID-19 outbreak was declared in the home and several days prior to the resident's death; however, it was not signed by resident #009's SDM. There was no indication on the form of a change or discussion about the resident's advanced directives prior to the COVID-19 outbreak in the home.

Review of resident #009's care plan and progress notes in PCC indicated that the resident's advanced directives were not reviewed or revised from March 30, 2020, when Directive #3 issued by the CMOH indicated that resident's advanced directives should be reviewed, until several days prior to their death. Although MD #105 indicated that they spoke with the resident's next of kin several days prior to their death about the goals of care for resident #009, it was not identified which family member was involved in this discussion. There were no revisions to the advanced directives section of the care plan during this period.

SDM #132 was interviewed and confirmed that before the COVID-19 outbreak was declared, no staff or physicians from the home spoke with them about their wishes for the resident's advanced directives. They confirmed that resident #009 was not capable of

having those discussions.

(ii) Review of the Advanced Directive form in resident #011's chart indicated that on a specified date soon after the resident's admission to the home, many years earlier, an advanced directive was put in place which was signed by the physician and resident #009's SDM. There were no revisions to this form. This same level of care was also documented in the resident's care plan in PCC with no revisions between March 30, 2020, when Directive #3 was issued with directions to review advanced directives, and the date the resident died.

Progress notes were reviewed for resident #011 and there were no notes identified that indicated a discussion had occurred with the resident or their SDM related to advanced directives.

SDM #140 indicated in an interview that they did not have any recent discussions about advanced directives with any staff or physicians from the home. They indicated that their expectation was that the resident received care as identified in the Advanced Directive initially signed by the SDM.

ADOC #103 confirmed in an interview that they were aware that residents' advanced directives were supposed to be reviewed prior to the COVID-19 outbreak, and that they were not reviewed. They explained that the home's medical director and physicians were responsible for having those discussions with residents and/or family members, and that they were not done consistently.

The licensee failed to ensure that Minister's Directives were followed as per Directive #3 when residents #008 and #011 developed respiratory symptoms and were not tested for COVID-19, and there was no review of the advanced directives for residents #009 and #011 prior to the COVID-19 outbreak in the home. [s. 174.1 (3)]

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 licensee of the long-term care home carries out every operational or policy directive that applies applies to the long-term care home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Review of resident #009's care plan indicated that they were to be bathed/showered according to their preference two times per week.

Review of the Observation/Flow Sheet Monitoring Form for resident #009 showed that the resident was last bathed/showered on a specified date; all entries on all shifts from that date until the resident died several weeks later indicated '8' (activity did not occur).

PSW #133 indicated during an interview that they could not recall if resident #009 was bathed/showered or received a bed bath leading up to their death; they also could not recall if the resident had been transferred out of bed. They stated that '8' in the flow sheet usually meant that the bath or shower had not occurred, and that 'BB' would be entered in the flow sheet if a bed bath was provided instead of the shower or bath.

ADOC #103 acknowledged that resident #009 should have been bathed/showered twice per week according the resident's care plan, or staff should have provided a bed bath if the resident was not well enough to get out of bed. The ADOC acknowledged that it may not have been done due to critical staff shortages over a specified period during the COVID-19 outbreak.

The licensee failed to ensure that resident #009 was bathed/showered as per their preference, or a complete bed bath, at least two times per week for a specified period during the COVID-19 outbreak. [s. 33. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, followed by the report required under subsection (4).

The progress notes in PCC were reviewed for resident #011, which indicated that over a specified period there was no indication of any health concerns other than an identified symptom on a specific date. Several days later, MD #147 entered a note that verified the resident did not have any specific health concerns. Shortly after the physician's note, the progress notes indicated that over a two-day period, the resident developed specified symptoms, interventions were initiated, and the resident died.

Review of resident #011’s care plan in PCC and Advanced Directives form in their health chart indicated that the resident was to receive a specified level of care when their condition deteriorated, and it had not been revised.

RPN #129 acknowledged during an interview that resident #011 had a significant change in their condition over a specified two-day period and deteriorated quickly. They stated that in their clinical experience, the resident died suddenly and unexpectedly.

SDM #140 was interviewed and indicated that they never expected the resident to die, and expected that the resident should have received care as specified in their advanced directives if they were not doing well. They indicated that on the day the resident died, they spoke with ADOC #103 in the morning to arrange a visit with the resident, then received a phone call several hours later to advise them that the resident was deceased. They considered resident #011’s death sudden and unexpected, and explained that they were never notified that the resident’s condition was deteriorating.

ADOC #103 acknowledged during an interview that resident #011 had died suddenly, although they said it may not have been unexpected given the circumstances with COVID-19 in the home and the resident’s underlying conditions. The ADOC acknowledged that in this instance, they should have reported the resident’s death to the MLTC and submitted a Critical Incident System (CIS) report. [s. 107. (1) 2.]

Issued on this 5th day of August, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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) :	COREY GREEN (722)
Inspection No. / No de l'inspection :	2020_816722_0008
Log No. / No de registre :	010167-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 24, 2020
Licensee / Titulaire de permis :	Gem Health Care Group Limited 470 Raglan Street North, RENFREW, ON, K7V-1P5
LTC Home / Foyer de SLD :	Downsview Long Term Care Centre 3595 Keele Street, NORTH YORK, ON, M3J-1M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Robert Scott

To Gem Health Care Group Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6.(7) of the LTCHA, 2007.

Specifically, the licensee must ensure that:

1. All residents are provided end-of-life care that is consistent with advanced directives specified in their plans of care;

2. When residents on Level 2, 3, or 4, have a significant change in their health status, and are not transferred to hospital, that there is clear documentation that the physician and a substitute decision maker have been notified and consented to the resident not being transferred to hospital, including the rationale as to why care may have deviated from the advanced directives specified in the plan of care;

3. Develop and implement a system in the home for capturing the documentation required under item 2. above.

4. Provide all registered staff with training on advanced directives and required actions when a resident has a significant change in their health status, including any new systems put in place to document variance from the plan of care related to advanced directives; and

5. All records related to staff training, including the content, schedules, and documentation of staff participation, are maintained and provided to an inspector when requested.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #008 and #011 as specified in their plans when their advanced directives were not followed.

(A) The MLTC received a complaint via the Action Line from resident #008's family member related to concerns with resident care prior to the resident's death and the COVID-19 outbreak in the home.

Resident #008's Advance Directive form was reviewed, which identified specified actions that staff were expected to take with a change in the resident's condition and that was signed by substitute decision maker (SDM) #137. At a later specified date, prior to the COVID-19 outbreak in the home, it was revised by MD #147 with verbal consent from the resident's SDM. The resident's care plan was reviewed and at the time of inspection the advanced directive had not been revised to reflect the change noted by MD #147. Also see findings under LTCHA, 2007, s. 6(1)(c) in inspection report #2020_816722_0010.

Review of the progress notes in PCC for resident #008 confirmed that on a specified date, during an identified shift, RN #127 identified that the resident's condition deteriorated, including potential symptoms of COVID-19. A note on the specified date indicated that the physician was informed, and the resident's family member had been notified and was comfortable with the actions taken by the home. There were no notes regarding the resident's status the following day. The next day, a note by RPN #138 indicated that the resident continued to deteriorate, MD #104 was notified, and specified interventions were put in place in the home. A note on the following day indicated that the family had been notified of the resident's declining status. The next day, the resident was deceased, and the notes showed that required actions specified in the advanced directive were not taken.

During an interview with the complainant, they indicated that when the resident deteriorated, actions specified in their advanced directive were not taken by staff in the home. They explained that on a specified date, the home contacted them and reported that resident #008 was not doing well. The complainant indicated that during that call, the nurse indicated that they were considering taking actions as specified in the advanced directive and that resident #008's SDMs had agreed with this action.

Resident #008's SDM #137 was interviewed and stated that on a specified date, they spoke with RN #127 by telephone and were informed that resident #008 was not doing well. The SDM stated that the RN asked them if they wanted to take actions as specified in the advanced directive, and the SDM indicated that they should take the specified action. They indicated that to their knowledge, the specified actions were never taken for resident #008 according to their wishes. They attempted to call the home for two days prior to resident #008's death and were unable to reach anyone. They also attempted to visit the home the day prior to the resident's death, but they were not allowed to enter.

RN #127 was interviewed, and confirmed that on a specified date, during the day shift, the resident had declined and specified interventions were put in place. They indicated that SDM #137 was notified and indicated that they did not want actions taken as specified in the resident's advanced directives. They indicated that the resident appeared to be doing better later in the day.

RPN #129 was interviewed and acknowledged that they worked on two specified dates prior to resident #008's death, and were assigned to provide care to the resident. They acknowledged that the resident's status had declined and they were aware of the actions that were specified in the resident's advanced directive. The RPN confirmed that they did not notify the doctor or take the actions as specified in the resident's advanced directive, and could not explain why that was the case.

(B) Resident #011 was reviewed as part of the complaint received by MD #104 related to concerns about resident care in the home during the COVID-19 outbreak, and deaths that occurred among residents who had never tested positive for COVID-19.

Review of resident #011's Advanced Directives form in their chart, as well as the care plan in PCC, indicated that as of a specified date, specified actions were required with a change in the resident's status as per their advanced directive.

The progress notes in PCC were reviewed for resident #011, which indicated that for a specified period there was no indication of any health concerns, which was supported by a note entered by MD #147. On a later specified date and

time, RPN #129 entered a note that indicated the resident was deteriorating with specified signs and symptoms. The next day, notes by RPN #136 and RPN #142 indicated that the resident continued to decline. At a specified time, RPN #142 indicated that they had received an order from MD #147 for specified treatment; however, there was no indication in the note that the registered staff discussed with the physician the actions required as per the resident's advanced directive. The notes indicated that several hours later on that same day that resident was deceased; there was no indication that specified actions required as per the advanced directive were taken.

SDM #140 was interviewed and indicated that they were never notified that resident #011 was declining. They indicated that they called the home daily for updates and were informed that the resident was doing fine. They indicated that the ADOC contacted them in the morning on a specified date and informed them that the resident was not responding. SDM #140 indicated that they requested to see the resident that day and the ADOC informed them they would call them back. They stated that Social Worker (SW) #146 called them later in the morning on the same date and notified them that the resident was deceased. The SDM further indicated that the SW read the notes to them and identified that the resident had started declining a week earlier and they did not understand why they were not notified.

RPN #129 was interviewed and acknowledged working on a specified date; they acknowledged that the resident's condition had deteriorated, which had started on the previous shift. They acknowledged that they did not notify the doctor of the resident's condition or take required actions as specified in the resident's advanced directive.

RPN #136 acknowledged during an interview that they worked on specified dates and that the expectation was that when a resident was declining, they follow their advanced directives and notify the doctor. The RPN confirmed that they did not notify the doctor or family of the resident's condition and indicated that they had notified ADOC #103 and the nurse manager, RPN #142, of the resident's declining condition before they went home at the end of their shift.

ADOC #103 confirmed during an interview that residents #008 and #011 both declined over a specified period, and that according to the Advanced Directives

in their plans of care, specified actions should have been taken when they deteriorated. Further, they stated that a specified intervention should have been initiated for resident #011 when they were identified in a specified condition. The ADOC further explained that they had been informed by Administrator #101, who no longer worked at the home, that they had received direction from ambulance services to only take specified actions for residents in the home as a last resort. They indicated that they were being discouraged from taking those specified actions, but were unsure where this direction came from.

ADOC #103 acknowledged that residents #008 and #011 did not receive care as set out in their plans of care when their advanced directives were not followed. [s. 6. (7)]

The severity of this issue was determined to be level 3, as there was actual risk to residents. The scope of this issue was a level 2 (pattern), as it impacted two of three residents reviewed. The home had a level 3 history of non-compliance with this subsection of the Act that included:
- Written notification issued May 1, 2019 (2019_654618_0016); and
- Voluntary Plan of Correction issued February 4, 2019 (2018_493652_0016). (722)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 08, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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

(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee shall be compliant with s. 26(4)(a) of the LTCHA, 2007.

Specifically, the licensee must ensure that:

1. There is a process in place to ensure that personal support workers (PSWs) notify registered staff when they are concerned about a resident's food or fluid intake, and that the notification is documented;

2. Registered staff make a referral to the registered dietitian (RD) when any resident has a significant change in their condition, including a pattern of decreased food/fluid intake, and/or a significant change in monthly weight;

3. The RD completes an assessment that is documented in the electronic health record for any resident who has a significant change in their health condition, including a pattern of decreased food or fluid intake, and/or a significant change in their monthly weight;

4. A system is developed and implemented in the home to ensure that registered staff and the RD are notified of significant changes in resident health condition, a pattern of decreased food or fluid intake, and significant changes in residents' monthly weights, which includes referrals to the RD as appropriate;

5. All staff receive training related to their role in communicating and documenting information based on the system developed in item #4, to ensure that the home's RD is notified of changes in resident condition, and completes nutritional assessments as required; and,

6. All documentation related to the system that is developed under item #4, including training content and logs detailing staff participation in training, is retained and provided to the inspector upon request.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the registered dietitian (RD), who is a member of the staff of the home, completed a nutritional assessment for residents #009 and #010 when there was a significant change in their health condition.

A complaint was received by the MLTC from MD #104, who identified general concerns with resident care, including deaths that occurred during the outbreak among residents who had never tested positive for COVID-19.

(A) Review of the progress notes in PCC for resident #009 indicated that during a specified period the resident had a change in their food and fluid intake. The notes indicated that the resident's clinical status declined and the resident died. There were no notes identified which indicated that the resident was referred to or assessed by the RD at any time during this period.

Review of the Nutrition and Hydration Flow Sheet showed that resident #009 had a change in their food and fluid intake over an identified period of time.

A Nutritional Assessment was reviewed which was completed on a specified date prior to the resident's declining health status, by the Food Services Supervisor #148, which identified that resident #009 was at a specified nutritional risk for several reasons. There were no Nutritional Assessments completed by the RD after the specified date.

PSW #133 confirmed in an interview that resident #009's food and fluid intake had changed leading up to their death. They indicated that they would attempt to provide assistance with feeding as per the resident's plan of care, but that it was not successful. They also confirmed that they notified the registered staff on shift, who were also not successful with providing the required level of assistance.

RPN #109 indicated in an interview that they had been responsible for resident #009's care, then was off for a specified duration, and returned on a specified date. They indicated that when they left, the resident's food and fluid intake was usual for the resident and when they returned, the resident's intake changed. They confirmed during the interview that the expectation was that residents should be referred to the RD when their food and fluid intake changed and confirmed that resident #009 was not referred to the RD for assessment.

(B) Review of the progress notes showed that resident #010 had a history of a specified level of food and fluid intake. There was an entry on a specified date which indicated that the RD assessed the resident. Notes on most days over a

specified period indicated that the resident's food and fluid intake had changed. On a specified date, there was a warning message in the progress notes which identified that resident #010 had a significant change in their weight on a previous specified date. In response to the warning, registered staff indicated that the resident's intake had changed, and that the physician, RD, and family were notified. Over a specified period, the progress notes indicated that the resident's health status continued to change significantly, with specified signs, symptoms, and interventions. The resident died on a specified date and there were no notes entered by the RD over this specified period of decline.

Review of the Nutrition and Hydration Flow Sheet showed that the resident's food and fluid intake had changed significantly over a specified period of time.

A Nutrition Assessment was completed by RD #131, prior to the resident's declining health status, and identified that resident #010 was at a specified level of nutritional risk. The assessment identified that the resident was ordered a specified nutritional supplement at the time of the assessment, and there were no further revisions to their care plan related to assistance with eating and/or other interventions.

RD #131 indicated during an interview that the expectation in the home was that they assess residents on admission, quarterly and with any significant change in their condition. They confirmed that both residents #009 and #010 had a significant change in their condition over a specified period, both residents had decreased food and fluid intake, and that they never assessed either resident because they did not receive a referral from registered staff. They also confirmed that they were not aware that resident #010 had a significant weight change on the specified date. They indicated that during this time, they were not receiving referrals from registered staff because poor intakes were such a widespread problem among residents in the home during the COVID-19 outbreak, and there was a critical staff shortage. The RD reported that they had sent a notice to all registered staff during this period that they could administer additional nutritional supplements if residents were not eating well.

ADOC #103 acknowledged during an interview that registered staff should have reviewed resident #009 and #010's food and fluid intakes daily, sent a referral to the RD when the residents' condition changed and their food and fluid intakes

changed, and the RD should have assessed the resident. The ADOC acknowledged that the RD likely did not receive referrals for residents #009 and #010 during this period because the home was critically short-staffed due to COVID-19, and there were many agency staff in the home. [s. 26. (4) (a),s. 26. (4) (b)]

The severity of this issue was determined to be a level 2, as there was minimal risk to residents. The scope of the issue was level 2 (pattern), as it related to two residents reviewed. The home had a level 2 compliance history, with no previous non-compliance to this subsection of the Regulations. (722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 08, 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 24th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Corey Green

Service Area Office /
Bureau régional de services : Toronto Service Area Office