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

Amended Public Copy/Copie modifiée 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
Oct 22, 2021	2021_526645_0011 (A1)	007739-21, 010003-21	Complaint

Licensee/Titulaire de permis

Gem Health Care Group Limited
15 Shoreham Lane, Suite 101 Halifax NS B3P 2R3

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

Amended by DEREGE GEDA (645) - (A1)

Amended 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): On-site: May 10, 13, 14, 17, 18, 20, 21, 25, 26, 27, 28, 31, June 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, July 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 2021. Off-site: July 19-23, 2021.

The following intakes were completed in this complaint inspection:

- Log# 007739-21 and log# 010003-21, both related to nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Manager (FSM), Nurse Manager (NM), Maintenance Service Supervisor, Social Worker (SW), Registered Dietitian (RD), Infection Control (IPAC) Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector observed the provision of care, services and supplies; reviewed records including but not limited to relevant training records, policies and procedures, residents' clinical health records, and staff schedules.

The following Inspection Protocols were used during this inspection:

Dining Observation
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Safe and Secure Home

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

4 WN(s)
0 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 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 :

(A1)
1. The licensee has failed to ensure that resident #006 had a nutritional assessment completed by the Registered Dietitian (RD) when they had a significant change in their health condition.

This inspection was initiated related to the Canadian Armed Forces (CAF) Augmented Civilian Care (ACC) team meeting minutes regarding concerns, alleging that residents were not fed and not offered fluids during the home's COVID-19 outbreak between January and June 2020.

The home’s Hydration Policy #H-10.80 effective February 2020, stated registered staff were to complete a dietary referral when a resident had a significant change in health condition.

Resident #006’s plan of care indicated the resident required assistance to eat and drink and an identified amount of fluid per day.

The progress notes for resident #006 indicated the resident had a significant change in health status, required treatments and passed away from an identified illness. The RD was not informed, and no assessment was completed when they had a significant change in their health condition.

Registered Practical Nurse(RPN) #103 and the RD stated that a referral was to be sent to the RD when there was a significant change in their health condition. The RD would then complete an assessment when the resident’s status changed.

When a dietary referral was not completed for resident #006, it put them at risk for further deterioration when additional interventions were not assessed or

implemented.

Sources: Review of resident #006's care plan, Hydration Policy #H-10.80 effective February 2020, and interview with RD.

2. The licensee has failed to ensure that resident #007 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #007 had a significant change in health status and was diagnosed with an identified illness.

The resident’s plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day.

Progress notes for resident #007 indicated that the RD was not informed, and assessment was not completed when the resident had a significant change in their health condition.

RPN #103 and the RD stated that when the resident’s status changed and their intake decreased, a referral or assessment was not completed.

When a dietary referral and assessment was not completed for resident #007, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident's #007 care plan, dietary assessments, progress notes and Hydration Policy #H-10.80 effective February 2020, interview with RPN #103, and the RD.

3. The licensee has failed to ensure that resident #004 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #004 was sent to hospital for treatment and had a significant change in health condition. The resident continued to decline and passed away. The progress notes did not indicate any assessment by the RD when the resident had a significant change in their health condition.

The RD acknowledged, during an interview, that they did not assess resident #004 as they were not notified about the change in condition.

When a dietary referral and assessment was not completed for resident #004, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Clinical records for resident #004 and interview with the RD.

4. The licensee has failed to ensure that resident #073 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

The progress notes for resident #073 indicated they had a significant change in their health condition requiring treatment. The resident's clinical condition continued to decline and was found with no vital signs in the same month. There were no notes identifying a referral for assessment by the RD at any time during this period.
Assessment documentation completed by the RD indicated that resident #073 was at high nutritional risk and there were no assessments completed by the RD.

The RD confirmed that they were not notified about the change in condition. A referral should have been sent to them so that the resident could have been assessed and interventions implemented.

When a dietary referral and assessment was not completed for resident #073, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: clinical records for resident #073 and interview with the RD.

5. The licensee has failed to ensure that resident #094 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #094 had a significant change in their health status, was transferred to the hospital, and passed away.

The resident's plan of care indicated they required assistance to eat and drink and

required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

A dietary referral or an assessment by the RD was not completed when resident #094's health condition declined. The RD acknowledged they did not receive a dietary referral and as a result did not complete an assessment of the resident.

When a dietary referral and assessment was not completed for resident #094, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #094's care plan, dietary assessments, progress notes, Hydration Policy #H-10.80 effective February 2020, and interviews with the RD, and RN #115.

6. The licensee has failed to ensure that resident #103 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #103's health condition deteriorated and passed away. The resident's plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

The resident had weight loss and decreased fluid intake. There was no dietary referral or assessment completed when the resident health condition changed. There was no documentation related to physician assessment or notifications.

The RD shared that they did not receive a referral to assess the resident.

When resident #103 had significant health changes, they were at risk for further deterioration when assessment and interventions were not completed and considered.

Sources: Review of resident #103's Care plan, dietary assessments, nutrition and hydration flow sheets, progress notes and Hydration Policy #H-10.80 effective February 2020, and interviews with the RD and RPN #116.

7. The licensee has failed to ensure that resident #021 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #021 had a significant change in their health status, was diagnosed with an identified illness, and passed away.

The resident's plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

The resident's fluid intake decreased and had a significant change in health condition. A dietary referral or assessment was not completed by the RD. The RD stated they did not receive a dietary referral for resident #021 and as a result did not complete an assessment.

When a dietary assessment was not completed for resident #021, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #021's care plan, nutrition and hydration flow sheets, progress notes, Hydration Policy #H-10.80 effective February 2020 and interview with the RD.

8. The licensee has failed to ensure that resident #030 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #030 had a significant change in their health condition and was found with no vital signs.

The resident's plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

There was no documentation identified in resident #030's clinical records to

indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary assessment was not completed for resident #030, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #030's care plan, nutrition and hydration flow sheets, progress notes, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.

9. The licensee has failed to ensure that resident #057 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

RD assessment indicated that the resident had an identified illness and required assistance to eat and drink. The plan of care for resident #057 indicated they required an identified amount of fluid per day, staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.
There was no documentation identified in resident #057's clinical records to indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #057, it put them at risk for further deterioration when intervention for nutrition and hydration were not assessed or implemented.

Sources: Review of resident #057's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, and interviews with the RD, and ADOC.

10. The licensee has failed to ensure that resident #032 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #032 had a significant change in their health status, was diagnosed with an identified illness and passed away.

The resident’s plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. Staff members were to monitor the resident’s fluid intake and notify the RD when there was a change in health condition.

There was no dietary referral, or an assessment completed by the RD when resident #032 had significant change in health condition.

The RD acknowledged that they did not assess the resident as there were no referrals made to them and indicated a referral should have been sent to assess the resident when they had a significant change in their health condition.

When a dietary referral and assessment was not completed for resident #032, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #032's care plan, nutrition and hydration flow sheets, progress notes, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.

11. The licensee has failed to ensure that resident #034 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #034 had a significant change in their health status, was diagnosed with an identified type of illness and passed away.

The plan of care for resident #034 indicated they required assistance to eat and drink and required an identified amount of fluid per day. Staff members were to monitor the resident’s fluid intake and notify the RD when there was a change in health condition.

There was no dietary referral, or an assessment completed by the RD when resident #034 had significant change in health condition.

The RD acknowledged that they did not assess the resident as there were no referrals made to them and indicated a referral should have been sent to assess the resident when they had a significant change in their health condition.

When a dietary referral and assessment was not completed for resident #034, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #034's care plan, nutrition and hydration flow sheets, progress notes for resident #034, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.

12. The licensee has failed to ensure that resident #058 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #058 had a significant change in their health condition and was found with no vital signs.

The RD assessment and the plan of care for resident #058 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident’s fluid intake and notify the RD when there was a change in health condition.

There was no documentation identified in resident #058’s clinical records to indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #058, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #058's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, and interviews with the RD and ADOC.

13. The licensee has failed to ensure that resident #035 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #035 had a significant change in their health condition, diagnosed with

identified illness and passed away.

The RD assessment and the plan of care for resident #035 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.
There was no documentation identified in resident #035's clinical records to indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #035, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #035's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, and interviews with the RD and ADOC.

14 The licensee has failed to ensure that resident #064 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #064 had a significant change in their health condition, diagnosed with an identified illness and passed away.

The plan of care for resident #064 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.
There was no documentation identified in resident #064's clinical records to indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #064, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #064's care plan, nutrition and hydration flow sheets,

progress notes for resident #064, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.

15. The licensee has failed to ensure that resident #066 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #066 was assessed by the physician who indicated the resident had a significant change in their health condition and directed staff to monitor the resident's health status. The resident condition further declined, diagnosed with an identified illness, and passed away.

The plan of care for resident #066 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

There was no dietary referral or an assessment by the RD completed when resident #066 had a significant change in their health condition. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #066, it put them at risk for further deterioration when interventions were not assessed or implemented.

Sources: Review of resident #066's care plan, nutrition and hydration flow sheets, progress notes for resident #066, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.

16. The licensee has failed to ensure that resident #054 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

The plan of care for resident #054 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

Resident #054 had a significant change in their health condition, was transferred to hospital and passed away from an identified illness.

A dietary referral or an assessment by the RD was not completed when resident #054 had a significant change in their health condition. The RD stated they did not receive a dietary referral, and as a result did not complete an assessment of the resident.

When a dietary referral and assessment was not completed for resident #054, it put them at risk for further deterioration when interventions were not assessed or implemented.

Sources: Review of resident #054's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, Hydration Policy #H-10.80 effective February 2020, and interviews with the RD, RN #115, RN #132, and RN #133.

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff.

In accordance with the definition identified in section 5 of the Regulation 79/10 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

The home's "Nutrition and Hydration policy, #NM-II-R015-0903-00" last reviewed in September 2020, directed staff members to notify the Registered Dietitian (RD) when the following occured:
• Change from usual pattern of food/fluid intake for two of the three meals over a period of seven days;
• Change in self-feeding ability affecting intake;
• When 25% or more fluid/food intake decreased for two of three meals over a period of seven days and
• Residents consume less than 1000 milliliter (ml) for three consecutive days (unless it was contraindicated by medical condition or was already assessed and documented upon by the RD).

A complaint inspection was initiated by Ministry of Long-Term Care (MLTC) on May 13, 2021, related to the Canadian Armed Forces (CAF) Augmented Civilian Care (ACC) team meeting minutes regarding concerns that dehydration was the cause of residents' death between January 2020 to June, 2020.

The progress notes indicated that the resident had a significant change in their health. There was no RD referral made or assessment completed when the resident's condition deteriorated. The progress notes indicated that the resident had lost a significant amount of weight. The staff took no action to assess or implement interventions to mitigate the decline in health condition.

The RD confirmed that they were not aware about the significant change in the resident's health condition and no RD assessment was completed. It was the expectation of the home that registered nursing staff notify the RD when the resident's health condition declined. They indicated that the resident's lab results were also indicative of poor health status.

The ADOC indicated that there was no assessment completed, and no new interventions were implemented when resident #001 had a significant change in their health condition. The ADOC indicated that the resident was neglected when staff did not notify the RD and physician to assess and consider interventions to improve the resident's status.

Sources: Review of resident #001's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, and interviews with the RD and ADOC.

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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. (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 :

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #021 as specified in their plan when their Advanced Care Directive was not followed.

Progress notes indicated that resident #021 had a significant change in their health condition, diagnosed with an identified illness, and was found without vital signs.

Resident #021's Advanced Care Directive and plan of care indicated that resident #021 required a specific type of intervention when their health condition change. The resident's clinical records indicated that the resident did not receive the identified intervention as specified in their plan of care when their health condition changed.

The Assistant Director of Care (ADOC) indicated that the resident did not receive care as specified in their plan of care.

Failure to assess, evaluate, and follow interventions as identified in the resident's plan of care may have contributed to the decline in the resident's health condition.

Sources: Care Plan for resident #021, progress notes and interview with the ADOC.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff participated in the implementation of the home's infection control program when they failed to wear personal protective equipment (PPE) and complete hand hygiene before and after entering and exiting a resident's environment.

The home's Routine Practices and Additional Precautions policy #ICM-VI-005 effective June 2020, stated that hand hygiene was to be performed with an alcohol-based hand rub or with soap and water before and after contact with the resident or their environment.

The document titled "Routine Practices and Additional Precautions In All Health Care Settings", 3rd Edition, revised November 2012, stated that a mask and eye protection must be worn by any individual who is within two meters of the resident, and gloves and gowns were required for activities that involve direct care where the health care provider's skin or clothing may come in direct contact with the resident or items in the resident's room or bed space.

Resident #117 was placed on an identified type of respiratory precautions and was isolating in their room. Inspector #729 observed RN #109 entering resident #117's room on an identified date and time. The RN was within two meters of the resident and was touching items in their environment. They did not don or doff a gown or gloves or complete hand hygiene before entering or leaving resident #117's room.

A staff member was observed entering resident #117's room and putting away the resident's laundry. They did not don or doff a gown, gloves or complete hand hygiene before entering or leaving resident #117's room. Then the staff member was observed entering residents #118's and #119's room. The staff member was not observed to perform hand hygiene before or after entering any of these residents' rooms.

The home's IPAC Lead #107, and Humber River Hospital IPAC team lead stated that it was their expectation that staff would don and doff the appropriate PPE which included a gown and gloves, and perform hand hygiene before entering and when exiting a resident's environment.

Residents were at risk when staff members did not comply with the home's IPAC policy and protocol.

Sources: Observations, review of the home’s Routine Practices and Additional Precautions policy #ICM-VI-005 effective June 2020, the document titled “Routine Practices and Additional Precautions In All Health Care Settings, 3rd Edition, revised November 2012, Interviews with PSW #103, Downsview IPAC Lead #107, and Humber River IPAC clinical coordinator team lead.

Issued on this 22nd day of October, 2021 (A1)

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DEREGE GEDA (645) - (A1)
Inspection No. / No de l'inspection :	2021_526645_0011 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	007739-21, 010003-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 22, 2021(A1)
Licensee / Titulaire de permis :	Gem Health Care Group Limited 15 Shoreham Lane, Suite 101, Halifax, NS, B3P-2R3
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

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

To Gem Health Care Group Limited, 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. 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 O.Reg 79/10.

Specifically, the licensee must ensure that:

1. Registered staff refer 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;

2. 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;

3. All staff receive training related to their role in communicating and documenting information to ensure that the home's RD is notified of changes in resident condition, and completes nutritional assessments as required; and,

4. All training documentation including logs detailing staff participation in training, is retained and provided to the inspector upon request.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that resident #006 had a nutritional assessment completed by the Registered Dietitian (RD) when they had a significant change in their health condition.

This inspection was initiated related to the Canadian Armed Forces (CAF) Augmented Civilian Care (ACC) team meeting minutes regarding concerns, alleging that residents were not fed and not offered fluids during the home's COVID-19 outbreak between January and June 2020.

The home's Hydration Policy #H-10.80 effective February 2020, stated registered staff were to complete a dietary referral when a resident had a significant change in health condition.

Resident #006's plan of care indicated the resident required assistance to eat and drink and an identified amount of fluid per day.

The progress notes for resident #006 indicated the resident had a significant change in health status, required treatments and passed away from an identified illness. The RD was not informed, and no assessment was completed when they had a significant change in their health condition.

Registered Practical Nurse(RPN) #103 and the RD stated that a referral was to be sent to the RD when there was a significant change in their health condition. The RD would then complete an assessment when the resident's status changed.

When a dietary referral was not completed for resident #006, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #006's care plan, Hydration Policy #H-10.80 effective February 2020, and interview with RD.
(729)

2. The licensee has failed to ensure that resident #007 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #007 had a significant change in health status and was diagnosed with an identified illness.

The resident's plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day.

Progress notes for resident #007 indicated that the RD was not informed, and assessment was not completed when the resident had a significant change in their health condition.

RPN #103 and the RD stated that when the resident's status changed and their intake decreased, a referral or assessment was not completed.

When a dietary referral and assessment was not completed for resident #007, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident's #007 care plan, dietary assessments, progress notes and Hydration Policy #H-10.80 effective February 2020, interview with RPN #103, and the RD.
(729)

3. The licensee has failed to ensure that resident #004 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #004 was sent to hospital for treatment and had a significant change in health condition. The resident continued to decline and passed away. The progress notes did not indicate any assessment by the RD when the resident had a significant change in their health condition.

The RD acknowledged, during an interview, that they did not assess resident #004 as they were not notified about the change in condition.

When a dietary referral and assessment was not completed for resident #004, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Clinical records for resident #004 and interview with the RD. (570)

4. The licensee has failed to ensure that resident #073 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

The progress notes for resident #073 indicated they had a significant change in their health condition requiring treatment. The resident's clinical condition continued to decline and was found with no vital signs in the same month.

There were no notes identifying a referral for assessment by the RD at any time during this period. Assessment documentation completed by the RD indicated that resident #073 was at high nutritional risk and there were no assessments completed by the RD.

The RD confirmed that they were not notified about the change in condition. A referral should have been sent to them so that the resident could have been assessed and interventions implemented.

When a dietary referral and assessment was not completed for resident #073, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: clinical records for resident #073 and interview with the RD.

(570)

5. The licensee has failed to ensure that resident #094 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #094 had a significant change in their health status, was transferred to the hospital, and passed away.

The resident's plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

A dietary referral or an assessment by the RD was not completed when resident #094's health condition declined. The RD acknowledged they did not receive a dietary referral and as a result did not complete an assessment of the resident.

When a dietary referral and assessment was not completed for resident #094, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #094's care plan, dietary assessments, progress notes, Hydration Policy #H-10.80 effective February 2020, and interviews with the RD, and RN #115.
(729)

6. The licensee has failed to ensure that resident #103 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #103's health condition deteriorated and passed away.

The resident's plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

The resident had weight loss and decreased fluid intake. There was no dietary referral or assessment completed when the resident health condition changed. There was no documentation related to physician assessment or notifications.

The RD shared that they did not receive a referral to assess the resident.

When resident #103 had significant health changes, they were at risk for further deterioration when assessment and interventions were not completed and considered.

Sources: Review of resident #103's Care plan, dietary assessments, nutrition and hydration flow sheets, progress notes and Hydration Policy #H-10.80 effective February 2020, and interviews with the RD and RPN #116.

(729)

7. The licensee has failed to ensure that resident #021 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #021 had a significant change in their health status, was diagnosed with an identified illness, and passed away.

The resident's plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

The resident's fluid intake decreased and had a significant change in health condition. A dietary referral or assessment was not completed by the RD. The RD stated they did not receive a dietary referral for resident #021 and as a result did not complete an assessment.

When a dietary assessment was not completed for resident #021, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #021's care plan, nutrition and hydration flow sheets, progress notes, Hydration Policy #H-10.80 effective February 2020 and interview with the RD.
(570)

8. The licensee has failed to ensure that resident #030 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #030 had a significant change in their health condition and was found with no vital signs.

The resident’s plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident’s fluid intake and notify the RD when there was a change in health condition.

There was no documentation identified in resident #030’s clinical records to indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary assessment was not completed for resident #030, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #030's care plan, nutrition and hydration flow sheets, progress notes, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.
(570)

9. The licensee has failed to ensure that resident #057 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

RD assessment indicated that the resident had an identified illness and required assistance to eat and drink. The plan of care for resident #057 indicated they required an identified amount of fluid per day, staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

There was no documentation identified in resident #057's clinical records to indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #057, it put them at risk for further deterioration when intervention for nutrition and hydration were not assessed or implemented.

Sources: Review of resident #057's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, and interviews with the RD, and ADOC.
(645)

10. The licensee has failed to ensure that resident #032 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #032 had a significant change in their health status, was diagnosed with an identified illness and passed away.

The resident's plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. Staff members were to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

There was no dietary referral, or an assessment completed by the RD when resident #032 had significant change in health condition.

The RD acknowledged that they did not assess the resident as there were no referrals made to them and indicated a referral should have been sent to assess the resident when they had a significant change in their health condition.

When a dietary referral and assessment was not completed for resident #032, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #032's care plan, nutrition and hydration flow sheets, progress notes, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.
(570)

11. The licensee has failed to ensure that resident #034 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #034 had a significant change in their health status, was diagnosed with an identified type of illness and passed away.

The plan of care for resident #034 indicated they required assistance to eat and drink and required an identified amount of fluid per day. Staff members were to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

There was no dietary referral, or an assessment completed by the RD when resident #034 had significant change in health condition.

The RD acknowledged that they did not assess the resident as there were no referrals made to them and indicated a referral should have been sent to assess the resident when they had a significant change in their health condition.

When a dietary referral and assessment was not completed for resident #034, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #034's care plan, nutrition and hydration flow sheets, progress notes for resident #034, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.
(570)

12. The licensee has failed to ensure that resident #058 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #058 had a significant change in their health condition and was found with no vital signs.

The RD assessment and the plan of care for resident #058 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

There was no documentation identified in resident #058's clinical records to indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #058, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #058's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, and interviews with the RD and ADOC.
(645)

13. The licensee has failed to ensure that resident #035 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #035 had a significant change in their health condition, diagnosed with identified illness and passed away.

The RD assessment and the plan of care for resident #035 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

There was no documentation identified in resident #035's clinical records to indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #035, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #035's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, and interviews with the RD and ADOC.
(645)

14. The licensee has failed to ensure that resident #064 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #064 had a significant change in their health condition, diagnosed with an identified illness and passed away.

The plan of care for resident #064 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident’s fluid intake and notify the RD when there was a change in health condition.

There was no documentation identified in resident #064’s clinical records to indicate the resident was referred to or assessed by the RD. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #064, it put them at risk for further deterioration when additional interventions were not assessed or implemented.

Sources: Review of resident #064's care plan, nutrition and hydration flow sheets, progress notes for resident #064, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.

(570)

15. The licensee has failed to ensure that resident #066 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

Resident #066 was assessed by the physician who indicated the resident had a significant change in their health condition and directed staff to monitor the resident's health status. The resident condition further declined, diagnosed with an identified illness, and passed away.

The plan of care for resident #066 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

There was no dietary referral or an assessment by the RD completed when resident #066 had a significant change in their health condition. The RD acknowledged that no referral was made, and as a result, did not complete the required assessment.

When a dietary referral and assessment was not completed for resident #066, it put them at risk for further deterioration when interventions were not assessed or implemented.

Sources: Review of resident #066's care plan, nutrition and hydration flow sheets, progress notes for resident #066, Hydration Policy #H-10.80 effective February 2020, and interview with the RD.
(570)

16. The licensee has failed to ensure that resident #054 had a nutritional assessment completed by the RD when they had a significant change in their health condition.

The plan of care for resident #054 indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

Resident #054 had a significant change in their health condition, was transferred to hospital and passed away from an identified illness.

A dietary referral or an assessment by the RD was not completed when resident

#054 had a significant change in their health condition. The RD stated they did not receive a dietary referral, and as a result did not complete an assessment of the resident.

When a dietary referral and assessment was not completed for resident #054, it put them at risk for further deterioration when interventions were not assessed or implemented.

Sources: Review of resident #054's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, Hydration Policy #H-10.80 effective February 2020, and interviews with the RD, RN #115, RN #132, and RN #133.

An order was made by taking the following factors into account:
Severity: There was actual risk to the residents when the home did not notify the RD or assess residents, who had significant change in their health status.

Scope: The scope was identified to be isolated incident because 16 out of 111 residents were not assessed by the Registered Dietitian following a significant change in condition.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 26 (4) and an Order (CO) was issued to the home on July 26, 2020, with a compliance due date of October 8, 2020, which has been complied.

(189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 30, 2021

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act.

Specifically the licensee must:

Ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff.

In accordance with the definition identified in section 5 of the Regulation 79/10 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

The home's "Nutrition and Hydration policy, #NM-II-R015-0903-00" last reviewed in September 2020, directed staff members to notify the Registered Dietitian (RD) when the following occurred:
- Change from usual pattern of food/fluid intake for two of the three meals over a period of seven days;
- Change in self-feeding ability affecting intake;
- When 25% or more fluid/food intake decreased for two of three meals over a period of seven days and

- Residents consume less than 1000 milliliter (ml) for three consecutive days (unless it was contraindicated by medical condition or was already assessed and documented upon by the RD).

A complaint inspection was initiated by Ministry of Long-Term Care (MLTC) on May 13, 2021, related to the Canadian Armed Forces (CAF) Augmented Civilian Care (ACC) team meeting minutes regarding concerns that dehydration was the cause of residents' death between January 2020 to June, 2020.

Progress notes indicated that resident #001 passed away from an identified illness. RD assessment and the plan of care indicated they required assistance to eat and drink and required an identified amount of fluid per day. The plan of care directed staff members to monitor the resident's fluid intake and notify the RD when there was a change in health condition.

The progress notes indicated that the resident had a significant change in their health. There was no RD referral made or assessment completed when the resident's condition deteriorated. The progress notes indicated that the resident had lost a significant amount of weight. The staff took no action to assess or implement interventions to mitigate the decline in health condition.

The RD confirmed that they were not aware about the significant change in the resident's health condition and no RD assessment was completed. It was the expectation of the home that registered nursing staff notify the RD when the resident's health condition declined. They indicated that the resident's lab results were also indicative of poor health status.

The ADOC indicated that there was no assessment completed, and no new interventions were implemented when resident #001 had a significant change in their health condition. The ADOC indicated that the resident was neglected when staff did not notify the RD and physician to assess and consider interventions to improve the resident's status.

Sources: Review of resident #001's care plan, dietary assessments, nutrition and hydration flow sheets, progress notes, and interviews with the RD and ADOC.

An order was made by taking the following factors into account:

Severity: There was actual risk to the resident when the home did not notify the RD or assess the resident when they had a significant change in health condition.
Scope: The scope was identified to be isolated incident as one out of 111 residents were found to be neglected by staff of the home.
Compliance History: 19 written notifications (WN), nine Voluntary Plans of Correction (VPC) and five Compliance Orders (CO) were issued to the home related to different sub-sections of the legislation in the past 36 months.
(645)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2021

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 22nd day of October, 2021 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by DEREGE GEDA (645) - (A1)

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