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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Jul 15, 2020	2020_748653_0013	002271-20, 002289-20, 010024-20, 010218-20, 010324-20, 010363-20, 010601-20, 010641-20, 010646-20, 012611-20	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Guildwood
60 Guildwood Parkway SCARBOROUGH ON M1E 1N9

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

ROMELA VILLASPIR (653), JACK SHI (760)

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): June 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, and 24, 2020.

During the course of the inspection, the following intakes were inspected:

Complaint Log #(s):
-002271-20 related to allegation of resident neglect, and insufficient Registered Nurse (RN) staffing;
-002289-20 related to personal care, pain management, personal support services, and the home's complaint procedures;
-010024-20 related to the residents not being fed and not receiving adequate hydration, residents not being repositioned nor allowed out of bed, and Infection Prevention and Control (IPAC) practices in the home;
-010218-20 related to nutrition and hydration concerns, and skin and wound care;
-010324-20 and 012611-20 related to nutrition and hydration concerns;
-010363-20 related to resident neglect, nutrition and hydration concerns, residents not properly dressed, and staff not provided with Personal Protective Equipment (PPE);
-010601-20 related to medication administration;
-010641-20 related to the residents' meals, staff not providing assistance with feeding, housekeeping concerns, lack of PPE, staff not responding to residents' call, medication administration, and personal hygiene concerns;
-010646-20 related to personal support services and nutrition and hydration concerns.

During the course of the inspection, the inspectors toured the home, observed the residents, provision of care, meal services, medication administration, IPAC practices, reviewed staffing schedule, clinical health records, complaint records, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist Assistant (PTA), Activity Aide (AA), Nursing Clerk (NC), Registered Dietitian (RD), Quality Risk Manager (QRM), Directors of Care (DOCs), and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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

8 WN(s)
6 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 collaborated with each other in the assessment of residents #002 and #016 so that their assessments were integrated, consistent with, and complemented each other.

The Ministry of Long-Term Care (MLTC) received a complaint regarding concerns related to resident #002's care in the home.

During a telephone interview, the complainant indicated that when resident #002's Family Member (FM) visited the resident at the home, the FM noted the resident was parched and their lips were dry.

A review of resident #002's progress notes indicated they passed away in the home.

A review of resident #002's written plan of care indicated their required assistance for eating, and their daily fluid target.

A review of resident #002's Point of Care (POC) look back report for their total food intake from an identified period indicated they consumed 50 per cent or less from their meals on some days, and refused their meals on other days.

Further review of POC documentation also revealed no records of food intake from some of resident #002's meals. The inspector requested for hard copy of the flow sheets that

the agency staff may have used to document resident #002's food and fluid intake, however, none was provided by the home.

A review of resident #002’s POC look back report for their total fluids meals/ snacks from an identified period indicated they consumed less than their individualized fluid target for four consecutive days. The aforementioned POC report was also missing documentation of fluid intake from some shifts.

A review of resident #002’s progress notes from an identified period, indicated documentations from the registered staff and the physician, regarding the resident not eating well and a decline in the resident's health condition.

Separate interviews with Personal Support Workers (PSWs) #106, #107, and Registered Practical Nurses (RPNs) #108, #100, and #126, indicated days before passing, resident #002’s health declined, and the resident had poor food and fluid intake. The staff were also pushing fluids on days the resident was able to handle it.

During separate interviews, RPNs #108, #100, and #126 acknowledged that a referral to the Registered Dietitian (RD) for resident #002, was not sent.

An interview with Director of Care (DOC) #128 and a review of their referral to the RD that was sent three days prior to resident #002's passing, indicated “significant change” in the description. When asked by the inspector what the reason was for the referral, the DOC indicated it may have been a call they had received from the family who complained that resident #002 was not eating well.

An interview with the RD acknowledged the DOC’s referral, however, the RD indicated they could not see what the referral was for as nothing was checked off on the reasons for referral. The RD stated they would not have assessed the resident’s food and fluid intake because they did not receive any referral from the nursing staff specifically for the resident’s poor food and fluid intake. The RD indicated they did not review POC documentation by PSWs, and only reviewed the progress notes by registered staff. The RD also stated they did not speak to the registered staff regarding resident #002's food and fluid intake. The RD further indicated if the resident did not meet their fluid target for three consecutive days, the registered staff were to complete the “Hydration Assessment”, which would have triggered a referral to the RD. The RD further indicated that if the staff noted that resident #002 was not eating their meals, they should have sent an RD referral as well. The RD stated had the registered staff informed the RD of

resident #002's poor food and fluid intake, they could have added it to the referral and the RD could have spoken to the resident's family and discuss options.

As per staff interviews and record reviews, the registered staff noted that resident #002 had a decline in their health condition resulting in poor food and fluid intake. The RD was not made aware of these assessments by the nursing staff, and when the RD responded to the DOC's referral, the RD did not incorporate the registered staff's assessments as the RD had not been made aware. The licensee has failed to ensure that the nursing staff and the RD collaborated with each other in the assessment of resident #002 so that their assessments were integrated, consistent with, and complemented each other. [s. 6. (4) (a)]

2. The MLTC received a complaint from resident #016's Substitute Decision-Maker (SDM) related to the care the resident received at the home, prior to their passing.

A review of the progress notes indicated that resident #016 was assessed by the registered staff on three different dates, and the resident had a significant change in their health condition. Further review of progress notes did not indicate that resident #016 was assessed by the physician nor the RD in the above mentioned dates.

An interview with RPN #100 indicated that it was only the registered staff and PSWs who were involved in addressing resident #016's decreased food and fluid intake.

An interview with RPN #126 indicated that there were a number of residents in the home who were not eating or drinking around this period. As a result, RPN #126 contacted the physician regarding general interventions for all the residents who were not eating nor drinking, but could not recall informing the physician specifically to address resident #016's decreased food and fluid intake.

An interview with DOC #128 indicated that an assessment should have been performed by the physician and the RD to address resident #016's change in status and provide specific interventions to the resident. DOC #128 indicated that if the physician was involved in assessing resident #016, they would have been able to make adjustments to their medications, due to their medical diagnosis, and decreased food and fluid intake. DOC #128 indicated that it would have been beneficial to resident #016, if the RD and the physician collaborated with the nursing team in their assessment of resident #016.

The licensee has failed to ensure that the staff and others involved in the different

aspects of care collaborated with each other in the assessment of resident #016 so that their assessments were integrated, consistent with, and complemented each other. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of resident #006 and #002's care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with, and complemented each other.

The MLTC received a complaint from resident #006’s SDM, related to the care the resident was receiving at the home, including nutrition and hydration concerns.

A review of resident #006’s chart on Point Click Care (PCC) indicated that a referral was sent to the RD, related to their responsive behaviour and refusal to eat during mealtimes. A subsequent referral was sent to the RD related to resident #006’s medical diagnosis, a new alteration in skin integrity, and weight loss. The RD addressed both referrals and added further interventions and supplements, which were reflected on the resident’s written plan of care. A review of the resident’s food and fluid records indicated that the PSWs were documenting resident #006’s intake both electronically and on paper.

A review of the paper document titled “Resident Daily Food and Fluid Intake Sheet” for resident #006, indicated that for a period of 8 days, there were three meals on two different dates wherein resident #006 did not have any food nor fluid intake. In addition, the intake documented between these periods did not show that resident #006 had a full meal nor drank more than four cups of fluids during a meal.

An interview with PSW #104 indicated that they were documenting the resident’s food and fluid intake on a paper chart because they did not have access to the home’s electronic system.

An interview with RPN #102 indicated they were not aware of the interventions that were being implemented for resident #006 by the RD. RPN #102 indicated they would document in the progress notes if they noticed resident #006 was refusing to eat or drink.

An interview with RPN #125 indicated that resident #006 required a lot of encouragement with their meals, due to their responsive behaviours.

An interview with the RD indicated that they were not able to review resident #006’s food

and fluid intake that were documented on paper, as they were not physically present at the home. The RD was not aware that the PSWs were documenting resident #006's intake on paper. The RD indicated they would be prompted to assess resident #006 through a dietary referral done by the nursing staff. Furthermore, the RD indicated that since they had not been on site at the home, the nursing staff may not have known to involve them in the care of resident #006.

An interview with DOC #128 indicated that as a result of newer staff and staff from the agency, the home had not been able to involve a collaboration with the RD and the nursing department in the development of interventions for resident #006. DOC #128 confirmed that the home failed to ensure there was collaboration between the nursing staff and the RD of the home in the development and implementation of the nutrition and hydration plan of care of resident #006. [s. 6. (4) (b)]

4. The MLTC received a complaint regarding concerns related to resident #002's care in the home.

During a telephone interview, the complainant indicated that when resident #002's FM visited the resident at the home, the FM noted the resident was parched and their lips were dry.

A review of resident #002's progress notes indicated they passed away in the home.

A review of resident #002's progress notes and an interview with the RD, indicated they received a referral for a significant change in the resident's status, three days prior to the resident's passing. The RD prescribed a dietary supplement, and entered the order on PCC under the category of dietary supplements. Further review of resident #002's progress notes on the morning prior to their passing, indicated that the resident was unable to tolerate their meal and distress was noted. The SDM was informed and the SDM requested for resident #002 to be hydrated. The physician was notified and a new treatment order was received.

During an interview, the inspector asked the RD how the new prescribed dietary supplement was communicated to the registered staff, and the RD indicated they did not speak to the registered staff as the order would have automatically reflected on the electronic Medication Administration Record (eMAR) after the RD had entered it on PCC. During the interview, the RD reviewed the PCC order they had entered, and it indicated that the order would not appear on the eMAR. A review of resident #002's eMAR and

eTAR did not reflect the RD’s order for the dietary supplement. The RD further acknowledged that the dietary supplement would not have been given by the registered staff to the resident as the order did not appear on the eMAR and the registered staff were not made aware. Further interview with the RD indicated they were not aware that the physician's treatment order was started on resident #002 on the morning prior to their passing.

As per staff interviews and record reviews, the registered staff noted that resident #002 had a decline in their health condition resulting in poor food and fluid intake. Three days prior to the resident's passing, the DOC sent a referral to the RD for significant change in the resident's status, due to a call they received from resident #002's family who complained that the resident was not eating well. The RD addressed the DOC's referral for resident #002's "significant change", and prescribed a dietary supplement, which was not provided to the resident as the registered staff were not made aware of the new dietary supplement order. On the morning prior to resident #002's passing, the resident's family requested for resident #002 to be hydrated, and the physician ordered a treatment. On the afternoon prior to the resident's passing, RPN #126 documented that the physician's treatment order was started on the resident. The RD did not speak to any nursing staff regarding the new dietary supplement they prescribed, and the RD was also not made aware by the nursing staff of the family's request to hydrate resident #002, as well as the physician's order. The licensee has failed to ensure that the staff and others involved in the different aspects of resident #002's care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with, and complemented each other. [s. 6. (4) (b)]

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

The MLTC received a complaint from resident #006’s SDM related to the care the resident was receiving at the home, including nutrition and hydration concerns.

A record review indicated that a referral was made to the RD and as a result, the RD ordered a dietary supplement for the resident.

A review of resident #006’s PCC physician orders indicated the order for the dietary supplement was entered by the RD into resident #006’s eMAR, under the heading of “Standard Dietary - Supplement (will not be on MAR)”. The original order entered in for the dietary supplement by the RD did not appear on the resident's eMAR and as a result,

the dietary supplement was not provided to resident #006 for about a month.

During separate interviews, RPNs #125 and #102 acknowledged that the prescribed dietary supplement was not provided to resident #006 as specified in their plan of care.

An interview with the RD verified that there was no documentation to support that resident #006 received the dietary supplement after it was ordered by the RD for resident #006. The RD indicated the issue was that the order did not reflect on the eMAR and as a result, nurses would not have known that resident #006 had the dietary supplement ordered for the resident.

An interview with DOC #128 confirmed that the staff did not provide resident #006's dietary supplement as specified in their plan of care.

The licensee has failed to ensure that the care set out in the written plan of care was provided to resident #006 as specified in the plan. [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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with.

According to Ontario Regulation (O. Reg.) 79/10, s. 114 (2), The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the home's policy titled “Medication Management”, #RC-16-01-07, effective December 2019, indicated the following under procedures: "Nurse: Administration: Administer scheduled medications according to the standard medication administration times". Further clarification from interim DOC #140 indicated that the home’s expectations with this policy would be to ensure that the medications were provided within an hour before or an hour after their scheduled administration time.

The MLTC received a complaint from resident #007's SDM, regarding an incident that occurred wherein the registered staff could not find resident #007’s medication, and that the staff were not following the directions from the physician’s order for this medication.

A review of resident #007’s chart indicated the order for their medication.

A review of the Physician's Orders Audit Report from an identified period, indicated that the medication was administered late to resident #007 on five different occasions.

An interview with RPN #105 indicated they worked on an identified day, and were late in their medication pass, including resident #007's medication administration.

An interview with RPN #126 indicated that they administered resident #007’s medication late on two occasions, according to their documentation on the eMAR.

An interview with RPN #115 indicated that they administered resident #007’s medication late on one occasion.

During an interview, interim DOC #140 indicated that the home’s expectations was to administer the medication to resident #007 an hour before or an hour after its scheduled administration time. [s. 8. (1) (b)]

2. Due to the area of non-compliance identified related to O. Reg. 79/10, s. 8 (1), the sample size was expanded to two additional residents, which included residents #008 and #011.

A review of resident #008's Physician's Orders Audit Report from an identified period, indicated late administration of the resident's morning medications, on an identified date.

A review of resident #011's Physician's Orders Audit Report from an identified period, indicated late administration of the resident's morning medications on nine different dates.

An interview with RPN #137 indicated they were late with administering resident #008’s medications on one occasion, and resident #011’s medications on two occasions.

An interview with RPN #102 indicated they were late with administering resident #011’s medications on seven different dates.

During an interview, DOC #128 acknowledged that the home's policy on medication management was not complied with in the late administration of medications to residents #007, #008, and #011.

The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward any written complaints that had been received by the home concerning the care of a resident or the operation of the home, to the Director.

The MLTC received a copy of a written complaint addressed by resident #001's SDM to Extendicare Guildwood's Administrator. Resident #001's SDM forwarded a copy of the written complaint to the MLTC. A review of the written complaint outlined concerns regarding resident #001's identified care not being strictly observed.

During the course of the inspection, the inspector requested for the home’s complaint records for 2020, from DOC #128, and the above mentioned written complaint from resident #001's SDM was found.

During a telephone interview, the Administrator acknowledged that resident #001’s SDM wrote fairly regular letters. The Administrator stated all written complaints that the home received were submitted to the Centralized Intake, Assessment and Triage Team (CIATT). However, there was no supporting documentation provided by the home, to indicate that resident #001’s SDM’s written complaint, was immediately forwarded to the Director. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home who receives a written complaint concerning the care of a resident or the operation of the long-term care home, shall immediately forward it to the Director, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home, completed a nutritional assessment on resident #016, when they had a significant change in their health condition.

The MLTC received a complaint from resident #016’s SDM related to the care the resident received at the home, prior to their passing.

A review of resident #016’s chart indicated they had poor fluid intake from an identified period. Further review of documentation indicated resident #016 refused to eat their meal and snack on a number of occasions, and there were also missing documentations of the resident's daily food and fluid intake during this period.

A review of the progress notes indicated that resident #016 was assessed by the registered staff on three different dates, and the resident had a significant change in their health condition. Further review of progress notes indicated that resident #016 continued to have poor intake. A review of resident #016’s chart did not indicate that any assessments were completed in relation to resident #016’s status at that period of time.

An interview with RPN #126 confirmed that PSW #149 indicated to them that resident #016 had a significant change in their health condition. RPN #126 further indicated they did not recall making a dietary referral for the resident.

An interview with the RD indicated that they were not made aware of resident #016’s decreased food and fluid intake, as they did not receive a referral from the registered staff. The RD confirmed that a nutritional assessment was not completed for resident #016, when they had a significant change in their condition.

An interview with DOC #128 indicated that according to the documentation, resident #016 had decreased food and fluid intake, and the resident had a significant change in condition. DOC #128 confirmed that a dietary referral was not sent, and a nutritional assessment was not completed when resident #016 had a significant change in their health condition.

The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home, completed a nutritional assessment on resident #016, when they had a significant change in their health condition. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian who was a member of the staff of the home, was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The MLTC received multiple complaints regarding nutrition and hydration concerns related to residents during the COVID-19 outbreak.

During a telephone interview on June 12, 2020, the RD indicated to Inspector #653 that they had not been on site at Extendicare Guildwood since the home's first COVID positive case was confirmed on April 23, 2020. During a follow-up telephone interview by Inspector #760 on June 15, 2020, the RD indicated they had been working remotely from home for Extendicare Guildwood and another LTC home. The RD stated they had not been on site at either of the LTC homes.

During the telephone interview with Inspector #653, the RD indicated prior to the COVID-19 outbreak, they worked on site at Extendicare Guildwood three times a week,

on Wednesday, Thursday, and Friday, for a full day. The RD stated their role in the home was to complete nutritional assessment upon resident admission, do the quarterly and annual Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessments, address significant weight changes, weight triggers, any referrals, skin breakdown, and swallowing assessments. Furthermore, the RD reviewed and approved the corporate menu twice a year. The RD would also feed residents if they had to do a swallowing or chewing assessment. The RD also updated the residents' fluid targets in the fluid binder at the nursing stations, on a monthly basis. When asked by the inspector how they were fulfilling their required minimum on site hours during the COVID-19 outbreak, the RD indicated, because they were no longer doing MDS assessments as it was put on hold, the RD was not putting in as much hours as they used to. The RD was not working on site at Extendicare Guildwood three days a week, and they would only invoice the home with the actual hours they worked off-site.

During a follow-up telephone interview by Inspector #760, the RD acknowledged they were not aware that agency staff were documenting the residents' food and fluid intake on a paper flow sheet at the nursing station. The RD further indicated they had not been on site at the home to review the flow sheets. The RD stated that collaboration with the nursing team was harder because they were not on site at the home, and the RD felt that the nursing staff may have thought that the RD was not working, or the agency staff were not aware that the RD was available off-site.

During an interview, DOC #128 indicated to Inspector #760 that the home had asked the RD if they can dedicate their services to the home, however, the RD initially declined as the RD was concerned about their health. The Administrator reached out to the RD and tried to have them on site and only at Extendicare Guildwood, however, the RD declined. Subsequently, the Administrator and the RD had a conversation, and the RD chose to work remotely from home.

Further interview conducted by Inspector #653 with DOC #128 indicated that the RD was considered an essential service, and when the RD was not on site, not all residents would have been assessed as the RD would have just relied on the dietary referrals. If the RD was on site at the home, the RD would have access to the residents' medical charts and would be able to do their own assessment based on the residents' concerns. The DOC further stated that the agency staff were doing documentations on paper, and the RD would not have had access to these paper documentations when they were working remotely from home.

Further interview conducted by Inspector #653 with DOC #128 acknowledged that the RD was not on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

In an e-mail correspondence to Inspector #653, the RD confirmed they returned working on site at Extendicare Guildwood on June 17, 2020. [s. 74. (2)]

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 a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #6: 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 :

1. The licensee has failed to ensure that the staff participated in the implementation of the infection prevention and control program.

The MLTC received complaints related to the poor Infection Prevention and Control (IPAC) practices in the home.

During the on site inspection, Inspector #653 observed multiple instances over several days in which the staff were not participating in the IPAC program, in relation to the use of Personal Protective Equipment (PPE), and disinfecting equipment.

During an interview, DOC #128 acknowledged the inspector's observations and that the observed staff practices were not in keeping with the home’s IPAC program. The DOC further indicated the home had provided IPAC education and training to their staff through internal and external resources such as Scarborough Health Network (SHN) and Public Health (PH), however, they had still been struggling with the IPAC practices of some of their staff including agency staff.

The licensee has failed to ensure that the staff participated in the implementation of the home's IPAC program. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times.

According to Long-Term Care Homes Act (LTCHA), s. 8 (3), Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The MLTC received a complaint on February 5, 2020, which indicated absences of Registered Nurses (RNs) in the home.

A review of the home's staffing schedule from January 1, 2020, inclusive to February 5, 2020, and as confirmed by Nursing Clerk #112, indicated there had been no RN on duty and present in the home on the following shifts:

-January 5, 8, 14, 17 22, and February 2, 2020, evening shifts;
-January 11, and 25, 2020, night shifts.

During a telephone interview, DOC #156 acknowledged that prior to COVID-19, the home received a compliance order in 2019, due to not having an RN on duty and present in the home at all times. The DOC further acknowledged that if the home's staffing schedule indicated there was no RN on duty and present in the home in the above mentioned dates, then the home was not in compliance with LTCHA, s. 8 (3).

Non-compliance was found under LTCHA, 2007, s. 8 (3), within inspection report #2019_702197_0025 and a compliance order was issued to the home on November 22, 2019, with the compliance due date of October 30, 2020. Therefore, a written notification will be issued within this inspection report #2020_748653_0013. [s. 8. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written complaint made to the licensee concerning the care of a resident or operation of the home, that a response has been made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

The MLTC received a copy of a written complaint addressed by resident #001's SDM to Extendicare Guildwood's Administrator. Resident #001's SDM forwarded a copy of the written complaint to the MLTC. A review of the written complaint outlined concerns regarding resident #001's identified care not being strictly observed.

Subsequently, the MLTC received a written complaint from resident #001’s SDM, wherein the SDM indicated there was no response to their letter from Extendicare Guildwood.

Administrator.

During the course of the inspection, the inspector requested for the home’s complaint records for 2020, from DOC #128, and the above mentioned written complaint from resident #001's SDM was found.

During a telephone interview on June 24, 2020, the Administrator indicated that for written complaints received by the home, they would respond back to the complainant in writing. The Administrator further acknowledged that resident #001’s SDM wrote fairly regular letters. Inspector #653 provided the Administrator up until July 3, 2020, to provide proof of response made to resident #001’s SDM addressing their written complaint. However, no proof of response was received by Inspector #653.

As per record reviews and interviews, the licensee has failed to ensure that a response was made to resident #001's SDM who had a written complaint addressed to the Administrator. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

The MLTC received a copy of a written complaint addressed by resident #001's SDM to Extendicare Guildwood's Administrator. Resident #001's SDM forwarded a copy of the written complaint to the MLTC. A review of the written complaint outlined concerns regarding resident #001's identified care not being strictly observed.

During the course of the inspection, the inspector requested for the home’s complaint records for 2020, from DOC #128, and the above mentioned written complaint from resident #001's SDM was found.

During a telephone interview on June 24, 2020, the Administrator indicated that for

written complaints received by the home, an Extendicare complaint template was used to log and document the complaint. The Administrator further acknowledged that resident #001’s SDM wrote fairly regular letters. Inspector #653 provided the Administrator up until July 3, 2020, to provide proof of documented record for the SDM’s written complaint. However, no documented record was received by Inspector #653.

A review of the home’s complaint records for 2020, and the telephone interview with the Administrator failed to demonstrate that a documented record was kept in the home that included the required information provided for in the regulation, for the above mentioned written complaint received by the home from resident #001’s SDM. [s. 101. (2)]

Issued on this 21st day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653), JACK SHI (760)
Inspection No. / No de l'inspection :	2020_748653_0013
Log No. / No de registre :	002271-20, 002289-20, 010024-20, 010218-20, 010324-20, 010363-20, 010601-20, 010641-20, 010646-20, 012611-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 15, 2020
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Guildwood 60 Guildwood Parkway, SCARBOROUGH, ON, M1E-1N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susanne Babic

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The licensee must be compliant with s. 6 (4) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee shall prepare, submit, and implement a written plan which includes but is not limited to the following elements:

1. A process to ensure that when there is a decline/ change in the resident's health condition, the assessments of all health care practitioners involved in the provision of care for that resident are seamlessly integrated and coordinated so that the appropriate and effective interventions are developed and implemented in a timely manner.

2. Ensure that all registered staff including the new hires and agency staff working in the home, clearly understand their role and responsibility in the assessment of the resident and in referring to other health care practitioners including but not limited to the Registered Dietitian (RD) and physician.

3. Ensure that the RD collaborates with the interdisciplinary team including but not limited to the nursing staff and the physician, before, during, and after completing their nutritional assessment when there is a decline/ change in the resident's health condition.

4. Develop an auditing or feedback process to ensure that items #1-3 are met.

5. The plan will identify persons responsible for implementing components of the plan, and timelines of implementation.

The plan is to be submitted by e-mail referencing report #2020_748653_0013 to Romela Villaspir, LTC Homes Inspector, MLTC, by August 4, 2020, and implemented by November 30, 2020.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the assessment of residents #002 and #016 so that their assessments were integrated, consistent with, and complemented each other.

The Ministry of Long-Term Care (MLTC) received a complaint regarding concerns related to resident #002’s care in the home.

During a telephone interview, the complainant indicated that when resident #002’s Family Member (FM) visited the resident at the home, the FM noted the resident was parched and their lips were dry.

A review of resident #002’s progress notes indicated they passed away in the home.

A review of resident #002’s written plan of care indicated their required assistance for eating, and their daily fluid target.

A review of resident #002’s Point of Care (POC) look back report for their total food intake from an identified period indicated they consumed 50 per cent or less from their meals on some days, and refused their meals on other days.

Further review of POC documentation also revealed no records of food intake from some of resident #002's meals. The inspector requested for hard copy of the flow sheets that the agency staff may have used to document resident #002's food and fluid intake, however, none was provided by the home.

A review of resident #002’s POC look back report for their total fluids meals/ snacks from an identified period indicated they consumed less than their individualized fluid target for four consecutive days. The aforementioned POC report was also missing documentation of fluid intake from some shifts.

A review of resident #002’s progress notes from an identified period, indicated documentations from the registered staff and the physician, regarding the resident not eating well and a decline in the resident's health condition.

Separate interviews with Personal Support Workers (PSWs) #106, #107, and Registered Practical Nurses (RPNs) #108, #100, and #126, indicated days before passing, resident #002’s health declined, and the resident had poor food and fluid intake. The staff were also pushing fluids on days the resident was able to handle it.

During separate interviews, RPNs #108, #100, and #126 acknowledged that a referral to the Registered Dietitian (RD) for resident #002, was not sent.

An interview with Director of Care (DOC) #128 and a review of their referral to the RD that was sent three days prior to resident #002's passing, indicated “significant change” in the description. When asked by the inspector what the reason was for the referral, the DOC indicated it may have been a call they had received from the family who complained that resident #002 was not eating well.

An interview with the RD acknowledged the DOC’s referral, however, the RD indicated they could not see what the referral was for as nothing was checked off on the reasons for referral. The RD stated they would not have assessed the resident’s food and fluid intake because they did not receive any referral from the nursing staff specifically for the resident’s poor food and fluid intake. The RD indicated they did not review POC documentation by PSWs, and only reviewed the progress notes by registered staff. The RD also stated they did not speak to the registered staff regarding resident #002's food and fluid intake. The RD further indicated if the resident did not meet their fluid target for three consecutive days, the registered staff were to complete the “Hydration Assessment”, which would have triggered a referral to the RD. The RD further indicated that if the staff noted that resident #002 was not eating their meals, they should have sent an RD referral as well. The RD stated had the registered staff informed the RD of resident #002's poor food and fluid intake, they could have added it to the referral and the RD could have spoken to the resident's family and discuss options.

As per staff interviews and record reviews, the registered staff noted that resident #002 had a decline in their health condition resulting in poor food and fluid intake. The RD was not made aware of these assessments by the nursing staff, and when the RD responded to the DOC’s referral, the RD did not incorporate the registered staff’s assessments as the RD had not been made aware. The licensee has failed to ensure that the nursing staff and the RD collaborated with each other in the assessment of resident #002 so that their assessments were integrated, consistent with, and complemented each other. (653)

2. The MLTC received a complaint from resident #016's Substitute Decision-Maker (SDM) related to the care the resident received at the home, prior to their passing.

A review of the progress notes indicated that resident #016 was assessed by the registered staff on three different dates, and the resident had a significant change in their health condition. Further review of progress notes did not indicate that resident #016 was assessed by the physician nor the RD in the above mentioned dates.

An interview with RPN #100 indicated that it was only the registered staff and PSWs who were involved in addressing resident #016's decreased food and fluid intake.

An interview with RPN #126 indicated that there were a number of residents in the home who were not eating or drinking around this period. As a result, RPN #126 contacted the physician regarding general interventions for all the residents who were not eating nor drinking, but could not recall informing the physician specifically to address resident #016's decreased food and fluid intake.

An interview with DOC #128 indicated that an assessment should have been performed by the physician and the RD to address resident #016's change in status and provide specific interventions to the resident. DOC #128 indicated that if the physician was involved in assessing resident #016, they would have been able to make adjustments to their medications, due to their medical diagnosis, and decreased food and fluid intake. DOC #128 indicated that it would have been beneficial to resident #016, if the RD and the physician collaborated with the nursing team in their assessment of resident #016.

The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #016 so that their assessments were integrated, consistent with, and complemented each other. (760)

3. The licensee has failed to ensure that the staff and others involved in the different aspects of resident #006 and #002's care collaborated with each other

in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with, and complemented each other.

The MLTC received a complaint from resident #006's SDM, related to the care the resident was receiving at the home, including nutrition and hydration concerns.

A review of resident #006's chart on Point Click Care (PCC) indicated that a referral was sent to the RD, related to their responsive behaviour and refusal to eat during mealtimes. A subsequent referral was sent to the RD related to resident #006's medical diagnosis, a new alteration in skin integrity, and weight loss. The RD addressed both referrals and added further interventions and supplements, which were reflected on the resident's written plan of care. A review of the resident's food and fluid records indicated that the PSWs were documenting resident #006's intake both electronically and on paper.

A review of the paper document titled "Resident Daily Food and Fluid Intake Sheet" for resident #006, indicated that for a period of 8 days, there were three meals on two different dates wherein resident #006 did not have any food nor fluid intake. In addition, the intake documented between these periods did not show that resident #006 had a full meal nor drank more than four cups of fluids during a meal.

An interview with PSW #104 indicated that they were documenting the resident's food and fluid intake on a paper chart because they did not have access to the home's electronic system.

An interview with RPN #102 indicated they were not aware of the interventions that were being implemented for resident #006 by the RD. RPN #102 indicated they would document in the progress notes if they noticed resident #006 was refusing to eat or drink.

An interview with RPN #125 indicated that resident #006 required a lot of encouragement with their meals, due to their responsive behaviours.

An interview with the RD indicated that they were not able to review resident

#006's food and fluid intake that were documented on paper, as they were not physically present at the home. The RD was not aware that the PSWs were documenting resident #006's intake on paper. The RD indicated they would be prompted to assess resident #006 through a dietary referral done by the nursing staff. Furthermore, the RD indicated that since they had not been on site at the home, the nursing staff may not have known to involve them in the care of resident #006.

An interview with DOC #128 indicated that as a result of newer staff and staff from the agency, the home had not been able to involve a collaboration with the RD and the nursing department in the development of interventions for resident #006. DOC #128 confirmed that the home failed to ensure there was collaboration between the nursing staff and the RD of the home in the development and implementation of the nutrition and hydration plan of care of resident #006. (760)

4. The MLTC received a complaint regarding concerns related to resident #002's care in the home.

During a telephone interview, the complainant indicated that when resident #002's FM visited the resident at the home, the FM noted the resident was parched and their lips were dry.

A review of resident #002's progress notes indicated they passed away in the home.

A review of resident #002's progress notes and an interview with the RD, indicated they received a referral for a significant change in the resident's status, three days prior to the resident's passing. The RD prescribed a dietary supplement, and entered the order on PCC under the category of dietary supplements. Further review of resident #002's progress notes on the morning prior to their passing, indicated that the resident was unable to tolerate their meal and distress was noted. The SDM was informed and the SDM requested for resident #002 to be hydrated. The physician was notified and a new treatment order was received.

During an interview, the inspector asked the RD how the new prescribed dietary

supplement was communicated to the registered staff, and the RD indicated they did not speak to the registered staff as the order would have automatically reflected on the electronic Medication Administration Record (eMAR) after the RD had entered it on PCC. During the interview, the RD reviewed the PCC order they had entered, and it indicated that the order would not appear on the eMAR. A review of resident #002's eMAR and eTAR did not reflect the RD's order for the dietary supplement. The RD further acknowledged that the dietary supplement would not have been given by the registered staff to the resident as the order did not appear on the eMAR and the registered staff were not made aware. Further interview with the RD indicated they were not aware that the physician's treatment order was started on resident #002 on the morning prior to their passing.

As per staff interviews and record reviews, the registered staff noted that resident #002 had a decline in their health condition resulting in poor food and fluid intake. Three days prior to the resident's passing, the DOC sent a referral to the RD for significant change in the resident's status, due to a call they received from resident #002's family who complained that the resident was not eating well. The RD addressed the DOC's referral for resident #002's "significant change", and prescribed a dietary supplement, which was not provided to the resident as the registered staff were not made aware of the new dietary supplement order. On the morning prior to resident #002's passing, the resident's family requested for resident #002 to be hydrated, and the physician ordered a treatment. On the afternoon prior to the resident's passing, RPN #126 documented that the physician's treatment order was started on the resident. The RD did not speak to any nursing staff regarding the new dietary supplement they prescribed, and the RD was also not made aware by the nursing staff of the family's request to hydrate resident #002, as well as the physician's order. The licensee has failed to ensure that the staff and others involved in the different aspects of resident #002's care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with, and complemented each other.

The severity of this issue was actual risk of harm to residents #002, #006, and #016. The scope of the issue was a pattern as it related to four of six residents reviewed. The home had previous areas of non-compliance to a different subsection. (653)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Nov 30, 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 15th day of July, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Romela Villaspir

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