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 14, 2020	2020_780699_0011 (A2)	010616-20, 010626-20	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

Amended by PRAVEENA SITTAMPALAM (699) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due date extended to December 11, 2020.

Issued on this 14th day of October, 2020 (A2)

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

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 14, 2020	2020_780699_0011 (A2)	010616-20, 010626-20	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

Amended by PRAVEENA SITTAMPALAM (699) - (A2)

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): June 16-19, 22-26, and 30, July 2-3, 6- 9, 2020. Off-site inspection dates July 15, and 17, 2020.

The following complaint logs were inspected during this inspection:

-Log # 010616-20, and 010626-20 related to alleged suspected neglect of resident #012.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Nurse Practitioner (NP), Environmental Services Manager (ESM), Registered Dietitian (RD), Registered Practical Nurse (RPN), Personal support workers (PSW), substitute decision makers (SDM), family members (FM), and residents.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, and relevant

policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

3 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #012 received end-of-life care when required in a manner that meets their needs.

Review of the physician's progress note indicated that resident #012 was experiencing poor oral intake and that they would discuss with the SDM related to the resident's poor prognosis. Further review of the progress notes, physician orders, and clinical health record did not indicate that resident #012 was assessed to be palliative, nor were there any end of life care orders.

The inspector reviewed an email communication between ED #100 and DOC #102 on a specific date regarding clarification if resident #012's status was changed to palliative. The DOC indicated they spoke with the nurse, and there was no order for end of life care in place. DOC #102 indicated that they left a voicemail with the physician requesting clarity. Review of the email communication did not indicate that there was any further follow up or if there was a response from the physician.

In an interview with physician #129, they stated that they could not recall if they spoke to resident #012's family regarding the resident's decline. The physician further indicated that they were not informed of the resident's continued decline and poor intake of food and fluids.

In an interview with RPN #168, they indicated there were no orders for end of life or palliative care. The RPN indicated that the physician and team knew the resident was declining and an identified intervention was provided as treatment. RPN #168 indicated that on a specified date, resident #012 had stopped eating, had low oxygen saturation and was advised by the DOC to initiate oxygen at 2 liters/minute, and call the family to come visit the resident. RPN #168 indicated that they asked family if they wanted resident #012 to be transferred to hospital, however family requested to come see the resident. The RPN indicated that comfort measures were initiated and that they were monitoring the resident's oxygen saturation. The resident subsequently passed away shortly after.

In interviews with NPs #115, and #154, who were in the building and NP #155 who was on call on that specified date, they indicated that they were not called by any nurse regarding resident #012's change in condition. They all indicated that they would have included a progress note if they had ordered end of life care or oxygen.

In an interview with family members #171 and #172, they indicated that when they arrived to the floor, they observed the resident in only their briefs, was unkempt with an identified substance in between their fingernails, and had appeared to have already passed away.

In an interview with DOC #102, they indicated they were called to the floor by ED #100 for assistance in locating the oxygen canisters on the specified date, and RPN #168 approached them regarding resident #012's change in condition. They could not recall whether they advised RPN #168 to start the oxygen. They indicated that they investigated the incident and was unable to determine who ordered the initiation of comfort measures. They acknowledged that the resident was not provided appropriate end of life care.

Resident #012 experienced a change of condition on a specified date, and subsequently passed away the same day. There was no order or direction from a physician or NP or consultation with the family regarding changing the resident's level of care to end of life. Comfort measures were initiated for the resident that only included oxygen saturation monitoring. The family indicated that resident #012 was found unkempt, identified substance noted in their fingernails and not dressed. Therefore the resident was not provided end of life care when required in a manner that meets their needs.

Additional Required Actions:

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

(A2)
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 O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written hot weather-related illness prevention and management plan that meets the needs of the resident was implemented when required to address the adverse effects on residents related to heat.

The Ministry of Long-term Care (MLTC) received complaints about the heat in the home at the end of May 2020. The complainant indicated that when they visited resident #012 on a specified date, their room was extremely warm.

The inspector requested air temperature logs of the home for May - June 2020, however the home was unable to locate the temperature logs for May and the beginning of June 2020.

The inspector conducted several observations in the home. On the following days, the inspector noted the temperature and humidity reading on the thermometers located in the nursing units:
-June 19, 2020: 26 degrees Celsius, 69% humidity on fourth floor, residents observed in rooms, light clothing on, no visible distress to residents noted;
-July 2, 2020: 26 degrees Celsius, 68% humidity on third floor, residents observed in rooms, light clothing on, no visible distress, curtains drawn; and
-July 7, 2020: 25 degrees Celsius, 70% humidity on second floor, residents observed in rooms, light clothing on, no visible distress, most of the lights in residents' rooms are off, curtains drawn.

Record review of the temperature logs from June 12-16, 2020, that were provided

to the inspector showed that daily temperatures were recorded twice a day, including humidity percentage on each floor. The document was titled "Daily Temperatures".

Review of the home's policy titled "Heat Contingency Protocols", policy number VII-G-10.30(a), last revised April 2019, indicated that there are three levels of intervention:
-Summertime practices: Relative Humidity is less than 50% and the indoor temperature is below 28 degrees Celsius;
-intervention alert: relative humidity is greater than 50% and the indoor temperature is 26 -32 degrees Celsius; and
-emergency alert: relative humidity is greater than 50% and the indoor temperature is 32 degrees Celsius or relative humidity is less than 50% but the indoor temperature is 34 degrees Celsius.

Further review of the policy showed that maintenance is responsible to record indoor temperature, humidity percentage from various location within the building daily, and document temperature on the electronic computerized maintenance system or Air Temperature Log. They would also be required to inform all departments of the heat contingency protocols to be implemented.

Review of the Air Temperature log form, policy number showed the three levels of interventions mentioned above, and indicated how to calculate the alert level utilizing the temperature and humidity readings, and then notify the nurse in charge if Intervention or Emergency alert is required. The "Daily Temperature" document that was being utilized from June 12-16, 2020, did not encompass the above information.

In an interview with RPN #164, they indicated that when the building is hot, they would turn of the lights on the unit, dress the residents in light clothing, and push hydration. They stated there was a period in May when the building was very hot, and management was notified. The only direction they received was to push fluid and turn off the lights. They further indicated that had not received any communication on July 2, 2020, from either management or maintenance, regarding the warm temperatures in the building and what intervention level to implement.

In an interview with RPN #163, they indicated that they were not advised by management or maintenance if the building was too hot or which heat intervention

to implement in the past two months. They indicated that previously, popsicles, watermelons would be brought up to the floor on hot days, however this has not occurred in the past two months.

Review of the home's policy titled "Hot Weather — Management of Risk", policy #VII-10.30, last revised April 2019, indicated the following should be done in the event of a heat alert, extreme heat alert, or heat wave:
-monitor residents for signs and symptoms of heat exhaustion and heat stroke and notify the nurse immediately if any occur;
-receive annual education/information on prevention and management of heat related illness and hot weather plans;
-offer residents popsicles and additional fluids between each meal and during the night if awake (1 Popsicle = 120mls of fluid) unless contraindicated on the plan of care.

In interviews with RPN #157 and #158, they both indicated that they did not receive training on the home's hot weather management policy.

Review of resident #012's clinical health record indicated that their heat risk level was an identified level and to encourage fluids. Further review of the resident's progress notes and clinical health record did not indicate resident was monitored for signs and symptoms of heat related illnesses in the last two weeks of May.

In an interview with DOC #102, they acknowledged that the appropriate air temperature logs were not consistent with the home's policies, alert levels were not being appropriately communicated to staff; and that the home's written hot weather-related illness prevention and management plan was not appropriately implemented.

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 written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat, to be implemented voluntarily.

WN #3: 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 :

1.The licensee has failed to ensure that resident #012 was protected or free from neglect by the licensee or staff in the home.

The MLTC received a complaint alleging suspected neglect of resident #012.

As per O. Reg. 79/10, s. 5, the definition of "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Review of resident #012's most recent clinical health record showed that the resident's code status was an identified level.

Record review of the physician orders on a specified date indicated lab work was ordered for the resident. Review of the lab work indicated that the lab tests were not drawn until 12 days after it was ordered.

Record review of resident #012's progress notes indicated that the resident was

assessed by the physician who reviewed the resident's bloodwork and noted that the resident had identified diagnoses. The resident was initiated on a specified treatment.

Review of the physician orders showed that the additional lab work was ordered. Upon review of progress notes and clinical health record, there was no indication that the lab work that was ordered was placed or completed.

Record review of resident #012's documentation survey showed that the resident had a decline in fluid and food intake over a ten day period.

Review of the physician's progress note indicated that resident #012 was experiencing poor oral intake and would discuss with the SDM regarding the resident's poor prognosis. Further review of the progress notes, physician orders, and clinical health record did not indicate that resident #012 was assessed to be palliative, nor were there any end-of-life care orders.

A referral to the registered dietician for resident #012 was completed for very poor oral intake. Review of the RD recommendations noted the resident had a decline in intake that started nine days prior to the referral. The RD initiated an intervention three times a day. Review of the RD's notes indicated that resident #012 might be at risk for an identified condition due to their decline in intake.

Review of resident #012's documentation survey of a specific nutritional intervention intake indicated that the resident only had a minimum intake over a nine day period.

Review of a progress note on a specific date indicated that a registered staff left a note for the physician regarding the resident's poor oral intake. Further review of the progress notes did not indicate that the physician received the communication or if there was any follow up related to resident #012's intake. The home was not able to provide the
physician communication documents as they could not be located.

Review of resident #012's care plan with full revision history and clinical health record did not indicate any reassessments of the resident's nutritional interventions when the resident's intake continued to decline, nor were there any indications that the physician or RD were informed of this decline during this time period.

On an identified date, it was noted that the resident had a change in condition. As per the progress notes, the family was informed and the NP ordered two liters of oxygen immediately. Further review of the note indicated that comfort measures were initiated. Resident #012 subsequently passed away that same day.

In an interview with physician #129, they indicated they ordered a specified treatment due to resident #012's lab work and was showing signs of an indicated diagnosis.
Physician #129 stated that they ordered the bloodwork to see the resident's response to the treatment. The physician further indicated that the resident's continued decrease in oral intake nor was the RD's assessment of the resident being at risk for an identified diagnosis were not communicated to them after the initiation of the specified treatment.
In an interview with RPN #163, they indicated that if a resident was observed with poor oral intake, they would initiate hydration monitoring. This would include monitoring vital signs every shift, assessing for signs of dehydration and document their intake throughout the shift. RPN #163 also indicated that they would send referrals to the physician and RD to assess the resident.

In an interview with RPN #161 , they indicated if a resident had less than 12 servings of fluid intake over three days, they would start hydration monitoring as per protocol. They further indicated that they would document in the progress notes the level of consciousness, signs and symptoms of dehydration, and vital signs each shift. RPN #161 indicated that the nurse manager and physician would be informed as well.

In an interview with RD #108, they indicated that if the resident was not consuming or tolerating the supplement that they had ordered, a referral should have been made to them to do a reassessment for the resident.

In an interview with RPN #168, they indicated that they did not receive detailed reports on resident #012 when they arrived to the floor due to severe staffing shortages. They were only informed that the resident was declining, and physician was aware, however was not told that the resident required any additional monitoring. RPN #168 indicated that the resident was not noted to be palliative or end-of-life. When the resident had a change in condition, they were informed by the DOC to call the family to come visit and initiate oxygen at 21-/minute. RPN #168 stated they did not know if a physician or NP were notified of the resident's

change of condition because they were new to the home during this time period, and had thought the DOC was the NP. RPN #168 stated that given the resident's condition, the resident should have been transferred to hospital prior to the resident's passing.

In an interview with DOC #102, they indicated that the home's definition of neglect was the failure to provide care and assistance required for the health and well being of the resident and a pattern of inaction that jeopardizes the health and well being of the resident. The DOC indicated that when resident #012 was exhibiting a decline in their oral intake, the resident should have been reassessed by the physician and RD. They further indicated that a plan of care should have been developed for monitoring of an identified condition for resident #012. DOC #102 indicated that they could not recall whether they told the RPN to call the family to come visit the resident or to order the oxygen. They indicated that if the resident's code status was an identified level, then the expectation would be for staff to follow that directive. DOC #102 acknowledged that resident #012 was not provided the care that they required.

This non compliance is additional evidence for a compliance order issued in inspection report #2020_780699_0014, that was inspected concurrently with this inspection.

Issued on this 14th day of October, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PRAVEENA SITTAMPALAM (699) - (A2)
Inspection No. / No de l'inspection :	2020_780699_0011 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	010616-20, 010626-20 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 14, 2020(A2)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kerri Judge

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Order / Ordre :

The licensee must be compliant with s. 42 of O.Reg. 79/10.

Specifically, the licensee must:

1. Upon receipt of this order, the interdisciplinary team must review any and all residents that are determined to be end-of-life and develop a written plan of care that specifies what end-of-life measures are in place for each resident.
2. Provide training to all direct care staff on end-of-life care based on the home's policy.
3. Keep a written record of the training content, including who will be responsible for providing the education, and the dates the training occurred. A written record of attendance must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #012 received end-of-life care when required in a manner that meets their needs.

Review of the physician's progress note indicated that resident #012 was experiencing poor oral intake and that they would discuss with the SDM related to the resident's poor prognosis. Further review of the progress notes, physician orders, and clinical health record did not indicate that resident #012 was assessed to be palliative, nor were there any end of life care orders.

The inspector reviewed an email communication between ED #100 and DOC #102

on a specific date regarding clarification if resident #012's status was changed to palliative. The DOC indicated they spoke with the nurse, and there was no order for end of life care in place. DOC #102 indicated that they left a voicemail with the physician requesting clarity. Review of the email communication did not indicate that there was any further follow up or if there was a response from the physician.

In an interview with physician #129, they stated that they could not recall if they spoke to resident #012's family regarding the resident's decline. The physician further indicated that they were not informed of the resident's continued decline and poor intake of food and fluids.

In an interview with RPN #168, they indicated there were no orders for end of life or palliative care. The RPN indicated that the physician and team knew the resident was declining and an identified intervention was provided as treatment. RPN #168 indicated that on a specified date, resident #012 had stopped eating, had low oxygen saturation and was advised by the DOC to initiate oxygen at 2 liters/minute, and call the family to come visit the resident. RPN #168 indicated that they asked family if they wanted resident #012 to be transferred to hospital, however family requested to come see the resident. The RPN indicated that comfort measures were initiated and that they were monitoring the resident's oxygen saturation. The resident subsequently passed away shortly after.

In interviews with NPs #115, and #154, who were in the building and NP #155 who was on call on that specified date, they indicated that they were not called by any nurse regarding resident #012's change in condition. They all indicated that they would have included a progress note if they had ordered end of life care or oxygen.

In an interview with family members #171 and #172, they indicated that when they arrived to the floor, they observed the resident in only their briefs, was unkempt with an identified substance in between their fingernails, and had appeared to have already passed away.

In an interview with DOC #102, they indicated they were called to the floor by ED #100 for assistance in locating the oxygen canisters on the specified date, and RPN #168 approached them regarding resident #012's change in condition. They could not recall whether they advised RPN #168 to start the oxygen. They indicated that they investigated the incident and was unable to determine who ordered the initiation

of comfort measures. They acknowledged that the resident was not provided appropriate end of life care.

Resident #012 experienced a change of condition on a specified date, and subsequently passed away the same day. There was no order or direction from a physician or NP or consultation with the family regarding changing the resident's level of care to end of life. Comfort measures were initiated for the resident that only included oxygen saturation monitoring. The family indicated that resident #012 was found unkempt, identified substance noted in their fingernails and not dressed. Therefore the resident was not provided end of life care when required in a manner that meets their needs.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the residents. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 2 history as there were previous non-compliances to a different subsection. (699)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2020(A2)

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:

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

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

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

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 14th day of October, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by PRAVEENA SITTAMPALAM (699) - (A2)

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

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