Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2018	2018_714673_0009	015918-18, 016030-18	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

Midland Gardens Care Community
130 Midland Avenue SCARBOROUGH ON M1N 4E6

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

BABITHA SHANMUGANANDAPALA (673)

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): July 5 & 6, 2018; and off-site interviews July 9-12, 2018.

The following intakes were completed during this complaint inspection:
-log #016030-18 and
-log #015918-18
related to concerns about the home lacking air conditioning and feeling extremely hot, residents over-heating and appearing to be hot and in distress.

During this inspection, the inspector conducted observations of residents, maintenance related systems in the home, and staff to resident care and interactions. The inspector also completed record review of the home's policies/procedures/plans, training records, documentation related to maintenance, and resident's medical records.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Maintenance and Environmental Lead (ML), Receptionist, Directors of Care (DOCs), Personal Sitters, Administrator, Building Services Partner (BSP), and a contractor with the home (HC).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **2 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	Legendé 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. 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).

s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Findings/Faits saillants :

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

On two identified dates, the Ministry of Health and Long-Term Care (MOHLTC) received complaints related to the home lacking air conditioning, and residents over-heating and appearing to be in distress as a result of the heat.

Review of the heat warnings issued by Toronto's Medical Officer of Health, as per the City of Toronto, indicated that a heat warning was issued on June 29, and 30, 2018, and extended heat warnings were issued on July 1-5, 2018. These dates included the identified dates of the heat related complaints received by the MOHLTC and the two dates that the inspector was physically present in the home for the inspection.

The inspector requested the written hot weather related illness prevention and management plan for the home and was provided with the following:
- A policy titled Hot Weather - Management of Risk, #VII-G-10.10 revised on November 2015
-Heat Contingency Protocols, #VII-G-10.10 (a) dated July 2015
-Heat related Information, #VII-G-10.10 (b) dated January 2015
-Air Temperature Log, #VII-G-10.10 (c)) dated September 2016

A review of the home's policy titled Hot Weather - Management of Risk, stated that in the

event of a heat alert or heat wave, staff are required to close all curtained areas and windows during the day to minimize heat, maintain residents' hydration with increased fluid, monitor residents for signs and symptoms of heat exhaustion and heat stroke and notify the registered staff immediately if any occur, dress residents in light clothing, assist registered staff to manage residents who may experience heat exhaustion or heat stroke, and follow protocols defined in "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes".

Review of the home's Heat Contingency Protocols indicated three threshold levels/contingency protocols including Summertime Practice, Intervention Alert, and Emergency Alert. Each threshold level had specific interventions for residents identified as being at high heat risk. During Summertime Practice, registered staff are to ensure that residents assessed to be at moderate to high heat risk receive care to prevent heat related illnesses and that staff are instructed regarding the importance of clothing and care during hot weather to prevent skin breakdown. Staff are to dress residents in one layer, loose, cotton clothing where available. During an Intervention alert, the interventions for Summertime Practice should be continued in addition to reporting the intervention alert to the RN Charge Nurse. Furthermore, nursing staff are responsible to ensure that only a light cover sheet is used on the bed, fans are not blowing directly on the resident, all in-room air conditioners are working, and that residents are encouraged to move to areas in the home with air conditioning.

A) On July 5, 2018, at an identified time, on a specified floor, the inspector observed that the curtains and window in resident #003 and #004's shared room had been left open. Resident #004 appeared agitated and continuously asked the inspector for a specified fluid. There were no fluids observed nearby for resident #004, and the resident stated that they had not had any fluids since breakfast.

A review of resident #004's medical records, including their most recently completed Minimum Data Set Resident Assessment Instrument (MDS-RAI) and current written plan of care, indicated that they had identified diagnoses and conditions. A review of resident #004's most recent heat risk assessment indicated an identified risk category for heat related illnesses as a result of resident #004's identified conditions. Specified interventions were also identified in resident #004's current written plan of care related to their identified risk category for heat related illnesses.

During observations of resident #003 and #004, PSW #100 was standing by the doorway of their room. PSW #100 stated that both residents were part of their assignment for the

shift. The inspector observed that PSW #100 did not try to get fluids nor respond to resident #004's request for fluids. When asked if resident #004 would be receiving fluids, PSW #100 stated that they could not leave the room due to an identified obligation. The inspector questioned whether they had requested another staff member to bring fluids and if there was any other way to communicate the resident's needs to staff on the unit from the room. PSW #100 only then proceeded to take action to obtain fluids for resident #004 by proceeding towards the call bell.

B) Resident #003, who was in the same room, was observed sleeping in bed covered up to the shoulders with one thin sheet and one thick blanket, and a fan nearby, blowing directly onto their face. Resident #003's face was observed to be red and flushed.

A record review of resident #003's medical records, including their most recently completed MDS-RAI and current written plan of care, stated that they had identified diagnoses, and conditions. A review of resident #003's most recent heat risk assessment indicated an identified risk category for heat related illnesses as a result of resident #003's identified conditions. Specified interventions were also identified in resident #003's current written plan of care related to their identified risk category for heat related illnesses.

During observations of the resident #003 and #004, PSW #100 who was standing by the doorway of their room, stated they had covered resident #003 with the sheet and blanket. PSW #100 did not make attempts to inform the nurse in charge of resident #003's condition.

The inspector alerted the RN #101 to resident #003's condition. RN #101 observed the resident and upon removing the sheets, resident #003 was noted to be wearing identified articles of clothing that were not consistent with the requirements under the home's Hot Weather - Management of Risk policy.

RN #101 was then observed to proceed to their medication cart, and discuss other issues with staff members. When RN #101 returned to take the resident's temperature, they stated that the covers for the thermometer were missing and that management had been informed to bring the covers. The inspector observed another thermometer in the hallway and when asked about it, RN #101 proceeded to use it to complete their assessment.

Approximately an hour from the time that RN #101 was first alerted to resident #003's

condition, resident #003 was observed to have remained lying in bed. When the Inspector questioned RN #101, they responded that they had directed PSW #100 to assist resident #003 to the cooling area in the dining room. When informed that resident #003 was still in bed, RN #101 stated that other residents were being brought out and 'that's the way they do things, one at a time". At 1145hrs, staff were observed to be assisting resident #003 out of bed. At this time, ML #102 took the temperature in resident #003 and #004's room and it was noted to be at 30 degrees Celsius.

It took approximately 25 minutes, and multiple interviews by the inspector from the time that RN #101 was first alerted to resident #003's condition to the time that resident #003's physical assessment was completed, and approximately an hour and a half for the resident to be assisted to a cooling area.

In an interview, RN #101 stated that compared to their initial observation of resident #003 at a time previous to this one during that same day, and based on their assessment of resident #003, resident #003 was experiencing an identified heat related illness. RN #101 also stated that it is the responsibility of the registered staff to monitor residents assessed to be in identified risk categories for heat related illnesses, and to instruct PSWs related to the required interventions under the home's hot weather related illness prevention and management plan such as keeping residents hydrated (especially those who remain in bed), closing curtains, dimming/turning off lights, changing residents into lighter clothes, and bringing them to the cooling area which is the dining room. When asked by the inspector how staff would ensure that all residents remain hydrated, RN #101 indicated that staff would implement appropriate interventions based on their heat assessment and plan of care. In an interview, RN #101 stated that the designated cooling areas on the units were in the dining rooms on each floor.

In an interview, PSW #100 stated the following:
- the home's cooling areas include the area around the nursing station, and an outdoors area designated for residents. PSW #100 could not identify the dining rooms as part of the designated cooling areas.
- they had not received information from RN #101, nor had they checked resident #003 and #004's plan of care in relation to their heat risk assessment and required interventions
- was not aware if a heat alert was in effect, or if it had been announced
- resident #003 was only provided two cups of fluids during breakfast, until the time the inspector arrived in the room
- and that they had positioned the fan towards resident #003's face, and covered them

with two blankets.

PSW #100 acknowledged that they should have checked the heat risk assessments and plan of care for both residents, should not have covered resident #003 with two sheets, and that they should have provided more fluids to resident #003.

In an interview, RN #101 stated the following:
- there were no heat alerts announced in the home that day
- they were not aware of the specific residents assessed to be at increased risk for heat related issues, and interventions to be implemented for these residents as they had not checked their care plans or the list containing these names at the start of their shift
- at the time of this interview, which took place approximately four hours after RN #101 was first alerted to resident #003 and #004's conditions by the inspector, RN #101 stated that they were still not aware of the heat risk level for residents #003 or #004, or their level of fluid intake as they still had not checked their written plans of care, heat assessments, or fluid documentation.

RN #101 and PSW #100 acknowledged that the staff's lack of knowledge related to the heat related assessments and the plans of care for the residents they were caring for, placed all residents including resident #003 and #004 at increased potential for risk/harm.

C) On July 5, 2018, on another identified floor at an identified time, resident #002 was observed in their room lying in bed, with no fan, and covered in one thin and one thick sheet. Resident #002 repeatedly stated that they were very hot so the inspector alerted registered staff to their concern.

A review of resident #002's medical records, including their most recently completed MDS-RAI and current written plan of care, indicated that they had identified diagnoses and conditions. A review of resident #002's most recent heat risk assessment indicated an identified risk category for heat related illnesses as a result of resident #002's identified conditions. Specified interventions were also identified in resident #004's most recent written plan of care related to their identified risk category for heat related illnesses.

In an interview, PSW #105 stated that resident #002 had an identified behaviour, but acknowledged that residents should not have two sheets covering them as per the hot weather related illness prevention and management plan for the home, and that they

could have removed the sheets from resident #002's bed, or taken resident #002 to the cooling area.

In interviews, PSW #105 and RN #104 indicated that they did not know what kind of heat alert the home was under, nor were they aware of the assessed risk levels for heat related issues for their assigned residents, including resident #002, as they had not checked their plans of care.

D) A review of the home's Heat Contingency Protocols and Air Temperature Log, VII-G-10.10 (c), stated that Maintenance or registered staff are required to record indoor temperature, outdoor temperature, and humidity percentages from various locations within the building daily between 1100hrs and 1500hrs whenever a hot weather alert is in effect. Furthermore, readings should be documented on the electronic computerized maintenance system or Air Temperature Log (VII-G-10.10 (c)), the alert level should be calculated, and the charge nurse and all departments should be informed of the heat contingency protocols to be implemented i.e. Intervention or Emergency Alert.

The home's record of temperatures and humidity taken from June 30 to July 6, 2018, were provided to the inspector. The log form used to document the readings was titled Midland Gardens Air Temperature and did not match the log form titled Air Temperature Log, VII-G-10.10 (c), which is the form required to be used as per the home's policy titled Hot Weather - Management of Risk #VII-G-10.10. In addition, review of the logs provided did not indicate specific locations that readings were taken from, if an alert level had been implemented, or if a charge nurse was notified. The recordings were taken only once during the day from June 30, to July 5, 2018, between the hours of 0845hrs and 1030hrs, instead of 1100hrs and 1500hrs, and did not include outdoor temperatures, and outdoor humidity recordings as required by the home's hot weather related illness prevention and management plan.

In an interview, ML #102 confirmed that maintenance staff record the temperatures and humidity levels taken from near the ends of the North and South corridors and inside the dining rooms of each floor, every morning by 1030hrs. ML #102 further stated that they provided the recordings to the receptionist every morning so that the receptionist could announce an alert in the home if required.

In interviews, ML #102 and DOC #106 acknowledged that taking the recordings once in the mornings before 1030hrs was not best practice as it may not accurately reflect the heat levels in the home throughout the day. DOC #106 further acknowledged that this

would result in not being able to implement appropriate interventions for residents assessed to be at high risk for heat related issues. DOC #106 also stated that the maintenance staff should be providing the DOCs with the readings so that the appropriate heat alert announcements could be made by them.

E) Further review of the logs completed July 2, 3, and 5, 2018, indicated that according to the home's thresholds, the home should have implemented an Intervention heat alert.

In an interview, Receptionist #103 stated that they had only received the temperature and humidity readings from ML #102 on Wednesday July 4, 2018, at an approximately identified time during the day, and that was the only time they had made a heat alert announcement to the home in the year of 2018. Receptionist #103 further stated that they are located in an area where they could hear all announcements but that they had neither made, nor heard, any other heat alerts being announced in the home on the two identified dates that the MOHLTC had received heat related complaints. There was also no announcement regarding a heat alert observed to have been made during the day on July 5, 2018, while the inspector was in the building.

In interviews, PSW #100, PSW #105, RN #104 and RN #101 stated they were unaware if the home had implemented a heat alert on the two identified dates that the MOHLTC had received heat related complaints, or July 5, 2018, as no one had communicated anything related to the alert in person or over the overhead announcement system.

The inspector communicated their findings related to the gaps in the implementation of the home's hot weather related illness prevention and management plan to DOC #106 at 1645hrs on July 5, 2018. An intervention alert was announced over the fire system following the discussion at 1711hrs.

In an interview, DOC #111 acknowledged that the hot weather related illness prevention and management plan for the home was not being followed, specifically in relation to:
- the care being provided to resident #002, #003 and resident #004 who were assessed to be at identified risk levels for heat related issues, as a result of staff not being aware of residents' heat risk assessments and interventions
-the lack of communication to staff when required about the heat risk level in the home
-completion of the recordings of temperatures and humidity levels from the required locations at the required times
-and usage of the correct documents as per the home's policy to record temperatures and humidity. [s. 20. (1)]

2. The licensee has failed to ensure that if central air conditioning is not available in the home, there is at least one separate designated cooling area available for every 40 residents.

In interviews RN #101 and #107 stated that residents who are assessed to be at high heat risk, or those suffering heat related health concerns would be taken to the dining rooms on the unit as they were the main cooling areas on each unit. The inspector observed on July 5, and 6, 2018, that the dining room doors on all units were left open throughout both days.

In an interview, ML #102 stated that they, or another maintenance worker, record the temperatures and humidity levels taken from near the ends of the north and south side corridors and inside the dining rooms on each floor every morning by 1030hrs.

Review of the home's policy titled Hot Weather - Management of Risk #VII-G-10.10 revised on November 2015, stated to follow the protocols defined in "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes". Review of these protocols indicated that humidex levels between 30 and 39 degrees Celsius will result in some people feeling uncomfortable and that some may begin to present with signs and symptoms of heat related illness.

Humidex levels were computed based on the home's record of temperatures and humidity taken from June 30 to July 6, 2018, and the Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes, as referred to in the home's policy. The following humidex levels were noted on specified dates and locations, specifically as it relates to the cooling areas (dining rooms) being at uncomfortable levels:

June 30, 2018 - 0945hrs
3rd floor: North: 35 South: 35 Dining Room: 36
4th floor: South: 34 Dining Room: 33
5th floor: South: 36 Dining Room: 35
6th floor: North: 37 Dining Room: 37

July 1, 2018 - 0915hrs
2nd floor: North: 35 Dining Room: 34
3rd floor: North: 35 South: 34 Dining Room: 35

July 2, 2018 - 0845hrs
2nd floor: North: 37 South: 36 Dining Room: 35
3rd floor: North: 36 South: 34 Dining Room: 35

July 3, 2018 - 1020hrs
3rd floor: North: 31 South: 29 Dining Room: 30
4th floor: North: 29 South: 31 Dining Room: 31
5th floor: North: 31 Dining Room: 30
6th floor: South: 29 Dining Room: 30

July 4, 2018 - 1015hrs
3rd floor: North: 31 South: 31 Dining Room: 30
4th floor: North: 31 South: 31 Dining Room: 31
5th floor: North: 30 South: 30 Dining Room: 30

July 5, 2018 - 1030hrs
2nd floor: North: 33 Dining Room: 32
6th floor: North: 33 South: 32 Dining Room: 32

July 6, 2018 - 0930hrs
2nd floor: South: 30 Dining Room: 30
5th floor: North: 31 South: 31 Dining Room: 30
6th floor: North: 31 South: 31 Dining Room: 32

Observation of the air conditioners on the sixth floor dining room revealed that one of them were not functioning. DOC #106 confirmed this observation.

In an interview, Administrator #109 stated that the expectation related to designated cooling areas in the home is that they are kept cooler than other areas in the home. Administrator #109 acknowledged that on the above mentioned dates, times and locations, the dining rooms could not be considered cooling areas because they were not cooler than the other areas of the home; therefore, these floors did not have designated cooling areas available as required. [s. 20. (2)]

Additional Required Actions:

CO # - 001, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the heating, ventilation, and air conditioning systems are cleaned and in good state of repair, and inspected at least every six months by a certified individual and that documentation is kept of the inspection. r. 20 (2)

On July 5, and 6, 2018, air conditioning units were observed in each of the dining rooms on each floor of the home. The dining rooms were identified by the staff as designated cooling areas.

The inspector requested documentation from the home to verify that the air conditioning units located in the dining rooms were cleaned, in a good state of repair, and inspected at least every six months by a certified individual. DOC #106 and BSP #112 provided a written contract and work orders from Absolute Alliance HVAC Solutions, and confirmed that this contractor was responsible for inspecting these units.

On July 6, 2018, the following observations were made of the air conditioning units located in the dining rooms, and were confirmed by DOC #106 and BSP #112:
-sixth floor: unit furthest to the kitchen was not functioning, and had multiple white, mold-like substances growing underneath the rail covers
-first floor: unit located in the Garden Lounge was also observed to have white, mold-like substances growing underneath the rail covers
-second floor: unit closest to the kitchen had its external covering falling off, and a unit in the middle of the room contained tissue and other debris inside the rails.

In an interview, HC #113, one of the contractors working with the home from Absolute Alliance HVAC Solutions stated that although the company performs work to repair the air conditioners in the dining rooms upon request by the home, preventative maintenance and inspections of these units were not being completed by the contractor every six months. [s. 90. (2) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 5th day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BABITHA SHANMUGANANDAPALA (673)
Inspection No. / No de l'inspection :	2018_714673_0009
Log No. / No de registre :	015918-18, 016030-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 18, 2018
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 :	Midland Gardens Care Community 130 Midland Avenue, SCARBOROUGH, ON, M1N-4E6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Fleming

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with r. 20 (1) of the LTCHA.

The licensee must prepare, submit and implement a plan to ensure that the written hot weather related illness prevention and management plan (HWRIPMP) for the home is implemented when required to address the adverse effects on residents related to heat.

The plan must include, but is not limited to the following:

1. Provision and documentation of education to all staff related to the HWRIPMP to ensure that staff understand their roles and responsibilities. This education should be completed before the end of May for each year going forward.
2. Steps that will be taken to ensure that the log form identified in the home's HWRIPMP is being used to document the monitoring of air temperatures and humidity in the locations and times as identified in the home's plan. The log form should also be used to document the heat alert level, if any, and the initials of the Charge Nurse informed of the heat alert level.
3. Steps to ensure effective communication about the heat contingency plan to all staff when required, as per the HWRIPMP, to minimize the risk of heat related illnesses to all residents.
4. Steps to ensure that staff are aware of residents' assessed heat risk levels, familiar with their plans of care, and implementing appropriate interventions as per their plan of care and the HWRIPMP.
5. Development and implementation of quality improvement initiatives such as documented audits to ensure the HWRIPMP is implemented and maintained when warranted.

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each objective/goal listed in the plan.

Please submit the written plan, quoting log #2018_714673_0009 and inspector Babitha Shanmuganandapala, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by July 27, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that a written hot weather related illness

prevention and management plan for the home that meets the needs of the residents was implemented when required to address the adverse effects on residents related to heat.

On two identified dates, the Ministry of Health and Long-Term Care (MOHLTC) received complaints related to the home lacking air conditioning, and residents over-heating and appearing to be in distress as a result of the heat.

Review of the heat warnings issued by Toronto's Medical Officer of Health, as per the City of Toronto, indicated that a heat warning was issued on June 29, and 30, 2018, and extended heat warnings were issued on July 1-5, 2018. These dates included the identified dates of the heat related complaints received by the MOHLTC and the two dates that the inspector was physically present in the home for the inspection.

The inspector requested the written hot weather related illness prevention and management plan for the home and was provided with the following:
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A review of the home's policy titled Hot Weather - Management of Risk, stated that in the event of a heat alert or heat wave, staff are required to close all curtained areas and windows during the day to minimize heat, maintain residents' hydration with increased fluid, monitor residents for signs and symptoms of heat exhaustion and heat stroke and notify the registered staff immediately if any occur, dress residents in light clothing, assist registered staff to manage residents who may experience heat exhaustion or heat stroke, and follow protocols defined in "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes".

Review of the home's Heat Contingency Protocols indicated three threshold levels/contingency protocols including Summertime Practice, Intervention Alert, and Emergency Alert. Each threshold level had specific interventions for residents identified as being at high heat risk. During Summertime Practice, registered staff are to ensure that residents assessed to be at moderate to high heat risk receive care to prevent heat related illnesses and that staff are

instructed regarding the importance of clothing and care during hot weather to prevent skin breakdown. Staff are to dress residents in one layer, loose, cotton clothing where available. During an Intervention alert, the interventions for Summertime Practice should be continued in addition to reporting the intervention alert to the RN Charge Nurse. Furthermore, nursing staff are responsible to ensure that only a light cover sheet is used on the bed, fans are not blowing directly on the resident, all in-room air conditioners are working, and that residents are encouraged to move to areas in the home with air conditioning.

A) On July 5, 2018, at an identified time, on a specified floor, the inspector observed that the curtains and window in resident #003 and #004's shared room had been left open. Resident #004 appeared agitated and continuously asked the inspector for a specified fluid. There were no fluids observed nearby for resident #004, and the resident stated that they had not had any fluids since breakfast.

A review of resident #004's medical records, including their most recently completed Minimum Data Set Resident Assessment Instrument (MDS-RAI) and current written plan of care, indicated that they had identified diagnoses and conditions. A review of resident #004's most recent heat risk assessment indicated an identified risk category for heat related illnesses as a result of resident #004's identified conditions. Specified interventions were also identified in resident #004's current written plan of care related to their identified risk category for heat related illnesses.

During observations of resident #003 and #004, PSW #100 was standing by the doorway of their room. PSW #100 stated that both residents were part of their assignment for the shift. The inspector observed that PSW #100 did not try to get fluids nor respond to resident #004's request for fluids. When asked if resident #004 would be receiving fluids, PSW #100 stated that they could not leave the room due to an identified obligation. The inspector questioned whether they had requested another staff member to bring fluids and if there was any other way to communicate the resident's needs to staff on the unit from the room. PSW #100 only then proceeded to take action to obtain fluids for resident #004 by proceeding towards the call bell.

B) Resident #003, who was in the same room, was observed sleeping in bed covered up to the shoulders with one thin sheet and one thick blanket, and a fan

nearby, blowing directly onto their face. Resident #003's face was observed to be red and flushed.

A record review of resident #003's medical records, including their most recently completed MDS-RAI and current written plan of care, stated that they had identified diagnoses, and conditions. A review of resident #003's most recent heat risk assessment indicated an identified risk category for heat related illnesses as a result of resident #003's identified conditions. Specified interventions were also identified in resident #003's current written plan of care related to their identified risk category for heat related illnesses.

During observations of the resident #003 and #004, PSW #100 who was standing by the doorway of their room, stated they had covered resident #003 with the sheet and blanket. PSW #100 did not make attempts to inform the nurse in charge of resident #003's condition.

The inspector alerted the RN #101 to resident #003's condition. RN #101 observed the resident and upon removing the sheets, resident #003 was noted to be wearing identified articles of clothing that were not consistent with the requirements under the home's Hot Weather - Management of Risk policy.

RN #101 was then observed to proceed to their medication cart, and discuss other issues with staff members. When RN #101 returned to take the resident's temperature, they stated that the covers for the thermometer were missing and that management had been informed to bring the covers. The inspector observed another thermometer in the hallway and when asked about it, RN #101 proceeded to use it to complete their assessment.

Approximately an hour from the time that RN #101 was first alerted to resident #003's condition, resident #003 was observed to have remained lying in bed. When the Inspector questioned RN #101, they responded that they had directed PSW #100 to assist resident #003 to the cooling area in the dining room. When informed that resident #003 was still in bed, RN #101 stated that other residents were being brought out and 'that's the way they do things, one at a time". At 1145hrs, staff were observed to be assisting resident #003 out of bed. At this time, ML #102 took the temperature in resident #003 and #004's room and it was noted to be at 30 degrees Celsius.

It took approximately 25 minutes, and multiple interviews by the inspector from

the time that RN #101 was first alerted to resident #003's condition to the time that resident #003's physical assessment was completed, and approximately an hour and a half for the resident to be assisted to a cooling area.

In an interview, RN #101 stated that compared to their initial observation of resident #003 at a time previous to this one during that same day, and based on their assessment of resident #003, resident #003 was experiencing an identified heat related illness. RN #101 also stated that it is the responsibility of the registered staff to monitor residents assessed to be in identified risk categories for heat related illnesses, and to instruct PSWs related to the required interventions under the home's hot weather related illness prevention and management plan such as keeping residents hydrated (especially those who remain in bed), closing curtains, dimming/turning off lights, changing residents into lighter clothes, and bringing them to the cooling area which is the dining room. When asked by the inspector how staff would ensure that all residents remain hydrated, RN #101 indicated that staff would implement appropriate interventions based on their heat assessment and plan of care. In an interview, RN #101 stated that the designated cooling areas on the units were in the dining rooms on each floor.

In an interview, PSW #100 stated the following:
- the home's cooling areas include the area around the nursing station, and an outdoors area designated for residents. PSW #100 could not identify the dining rooms as part of the designated cooling areas.
- they had not received information from RN #101, nor had they checked resident #003 and #004's plan of care in relation to their heat risk assessment and required interventions
- was not aware if a heat alert was in effect, or if it had been announced
- resident #003 was only provided two cups of fluids during breakfast, until the time the inspector arrived in the room
- and that they had positioned the fan towards resident #003's face, and covered them with two blankets.

PSW #100 acknowledged that they should have checked the heat risk assessments and plan of care for both residents, should not have covered resident #003 with two sheets, and that they should have provided more fluids to resident #003.

In an interview, RN #101 stated the following:

- there were no heat alerts announced in the home that day
- they were not aware of the specific residents assessed to be at increased risk for heat related issues, and interventions to be implemented for these residents as they had not checked their care plans or the list containing these names at the start of their shift
- at the time of this interview, which took place approximately four hours after RN #101 was first alerted to resident #003 and #004's conditions by the inspector, RN #101 stated that they were still not aware of the heat risk level for residents #003 or #004, or their level of fluid intake as they still had not checked their written plans of care, heat assessments, or fluid documentation.

RN #101 and PSW #100 acknowledged that the staff's lack of knowledge related to the heat related assessments and the plans of care for the residents they were caring for, placed all residents including resident #003 and #004 at increased potential for risk/harm.

C) On July 5, 2018, on another identified floor at an identified time, resident #002 was observed in their room lying in bed, with no fan, and covered in one thin and one thick sheet. Resident #002 repeatedly stated that they were very hot so the inspector alerted registered staff to their concern.

A review of resident #002's medical records, including their most recently completed MDS-RAI and current written plan of care, indicated that they had identified diagnoses and conditions. A review of resident #002's most recent heat risk assessment indicated an identified risk category for heat related illnesses as a result of resident #002's identified conditions. Specified interventions were also identified in resident #004's most recent written plan of care related to their identified risk category for heat related illnesses.

In an interview, PSW #105 stated that resident #002 had an identified behaviour, but acknowledged that residents should not have two sheets covering them as per the hot weather related illness prevention and management plan for the home, and that they could have removed the sheets from resident #002's bed, or taken resident #002 to the cooling area.

In interviews, PSW #105 and RN #104 indicated that they did not know what kind of heat alert the home was under, nor were they aware of the assessed risk levels for heat related issues for their assigned residents, including resident #002, as they had not checked their plans of care.

D) A review of the home's Heat Contingency Protocols and Air Temperature Log, VII-G-10.10 (c), stated that Maintenance or registered staff are required to record indoor temperature, outdoor temperature, and humidity percentages from various locations within the building daily between 1100hrs and 1500hrs whenever a hot weather alert is in effect. Furthermore, readings should be documented on the electronic computerized maintenance system or Air Temperature Log (VII-G-10.10 (c)), the alert level should be calculated, and the charge nurse and all departments should be informed of the heat contingency protocols to be implemented i.e. Intervention or Emergency Alert.

The home's record of temperatures and humidity taken from June 30 to July 6, 2018, were provided to the inspector. The log form used to document the readings was titled Midland Gardens Air Temperature and did not match the log form titled Air Temperature Log, VII-G-10.10 (c), which is the form required to be used as per the home's policy titled Hot Weather - Management of Risk #VII-G-10.10. In addition, review of the logs provided did not indicate specific locations that readings were taken from, if an alert level had been implemented, or if a charge nurse was notified. The recordings were taken only once during the day from June 30, to July 5, 2018, between the hours of 0845hrs and 1030hrs, instead of 1100hrs and 1500hrs, and did not include outdoor temperatures, and outdoor humidity recordings as required by the home's hot weather related illness prevention and management plan.

In an interview, ML #102 confirmed that maintenance staff record the temperatures and humidity levels taken from near the ends of the North and South corridors and inside the dining rooms of each floor, every morning by 1030hrs. ML #102 further stated that they provided the recordings to the receptionist every morning so that the receptionist could announce an alert in the home if required.

In interviews, ML #102 and DOC #106 acknowledged that taking the recordings once in the mornings before 1030hrs was not best practice as it may not accurately reflect the heat levels in the home throughout the day. DOC #106 further acknowledged that this would result in not being able to implement appropriate interventions for residents assessed to be at high risk for heat related issues. DOC #106 also stated that the maintenance staff should be providing the DOCs with the readings so that the appropriate heat alert announcements could be made by them.

E) Further review of the logs completed July 2, 3, and 5, 2018, indicated that according to the home's thresholds, the home should have implemented an Intervention heat alert.

In an interview, Receptionist #103 stated that they had only received the temperature and humidity readings from ML #102 on Wednesday July 4, 2018, at an approximately identified time during the day, and that was the only time they had made a heat alert announcement to the home in the year of 2018. Receptionist #103 further stated that they are located in an area where they could hear all announcements but that they had neither made, nor heard, any other heat alerts being announced in the home on the two identified dates that the MOHLTC had received heat related complaints. There was also no announcement regarding a heat alert observed to have been made during the day on July 5, 2018, while the inspector was in the building.

In interviews, PSW #100, PSW #105, RN #104 and RN #101 stated they were unaware if the home had implemented a heat alert on the two identified dates that the MOHLTC had received heat related complaints, or July 5, 2018, as no one had communicated anything related to the alert in person or over the overhead announcement system.

The inspector communicated their findings related to the gaps in the implementation of the home's hot weather related illness prevention and management plan to DOC #106 at 1645hrs on July 5, 2018. An intervention alert was announced over the fire system following the discussion at 1711hrs.

In an interview, DOC #111 acknowledged that the hot weather related illness prevention and management plan for the home was not being followed, specifically in relation to:
- the care being provided to resident #002, #003 and resident #004 who were assessed to be at identified risk levels for heat related issues, as a result of staff not being aware of residents' heat risk assessments and interventions
-the lack of communication to staff when required about the heat risk level in the home
-completion of the recordings of temperatures and humidity levels from the required locations at the required times
-and usage of the correct documents as per the home's policy to record temperatures and humidity. [s. 20. (1)]

The severity of this issue was determined to be a level 2 as there was minimal harm, and potential for actual harm to the residents. The scope of the issue was a level three as it related to all residents. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:

-written notification (WN) issued August 8, 2016 (2016_377502_0011);
-and immediate compliance order issued August 12, 2016, with a compliance due date of the same day (2016_353589_0016).

Due to the severity, scope, and history, a compliance order and Director's Referral is warranted. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 07, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee must be compliant with r.90 (2) of the LTCHA.

Specifically, the licensee must ensure that all heating, ventilation, and air conditioning systems, including all air conditioning systems located in designated cooling areas, are cleaned, in good state of repair, and inspected at least every six months by a certified individual, and that documentation is kept of the inspection.

Grounds / Motifs :

1. The licensee has failed to ensure that the heating, ventilation, and air conditioning systems are cleaned and in good state of repair, and inspected at least every six months by a certified individual and that documentation is kept of the inspection. r. 20 (2)

On July 5, and 6, 2018, air conditioning units were observed in each of the dining rooms on each floor of the home. The dining rooms were identified by the staff as designated cooling areas.

The inspector requested documentation from the home to verify that the air conditioning units located in the dining rooms were cleaned, in a good state of repair, and inspected at least every six months by a certified individual. DOC #106 and BSP #112 provided a written contract and work orders from Absolute Alliance HVAC Solutions, and confirmed that this contractor was responsible for inspecting these units.

On July 6, 2018, the following observations were made of the air conditioning units located in the dining rooms, and were confirmed by DOC #106 and BSP #112:
-sixth floor: unit furthest to the kitchen was not functioning, and had multiple white, mold-like substances growing underneath the rail covers
-first floor: unit located in the Garden Lounge was also observed to have white, mold-like substances growing underneath the rail covers
-second floor: unit closest to the kitchen had its external covering falling off, and a unit in the middle of the room contained tissue and other debris inside the rails.

In an interview, HC #113, one of the contractors working with the home from Absolute Alliance HVAC Solutions stated that although the company performs work to repair the air conditioners in the dining rooms upon request by the home,

preventative maintenance and inspections of these units were not being completed by the contractor every six months. [s. 90. (2) (c)]

The severity of this issue was determined to be a level 2 as there was minimal harm and potential for actual harm to the residents. The scope of the issue was a level 3 as it related to three air conditioning systems throughout the home, and all residents in the home. The home had a level 2 history as they had previous unrelated noncompliances.

Due to the severity, scope, and history, a compliance order and Director's Referral is warranted. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 07, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Order / Ordre :

The licensee must be compliant with r. 20 (2) of the LTCHA.

The licensee must prepare, submit and implement a plan to ensure that if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents.

The plan must include, but is not limited to the following:

1. Steps that will be taken to ensure that the log form identified in the home's HWRIPMP is being completed, and is being used to document the monitoring of air temperatures and humidity in the locations and times as identified in the home's plan.
2. Steps to ensure that all air conditioners in the designated cooling areas are effective and functional, inspected by a qualified individual, and maintained so that the designated cooling areas are kept cooler than other areas of the home, and as comfortable of a humidex level as possible.
3. A plan of how the home will ensure that each designated cooling area will be kept cooler than other areas of the home, and at a comfortable of a humidex level as possible until such time that all of the air conditioners in the designated cooling areas are functional, inspected and maintained.
4. Development and implementation of quality improvement initiatives such as documented audits to ensure steps one to three mentioned above are implemented and maintained when warranted.

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each objective/goal listed in the plan.

Please submit the written plan, quoting log #2018_714673_0009 and inspector Babitha Shanmuganandapala, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by July 27, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that if central air conditioning is not available in the home, there is at least one separate designated cooling area available for every 40 residents.

In interviews RN #101 and #107 stated that residents who are assessed to be at high heat risk, or those suffering heat related health concerns would be taken to the dining rooms on the unit as they were the main cooling areas on each unit. The inspector observed on July 5, and 6, 2018, that the dining room doors on all units were left open throughout both days.

In an interview, ML #102 stated that they, or another maintenance worker, record the temperatures and humidity levels taken from near the ends of the north and south side corridors and inside the dining rooms on each floor every morning by 1030hrs.

Review of the home's policy titled Hot Weather - Management of Risk #VII-G-10.10 revised on November 2015, stated to follow the protocols defined in "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes". Review of these protocols indicated that humidex levels between 30 and 39 degrees Celsius will result in some people feeling uncomfortable and that some may begin to present with signs and symptoms of heat related illness.

Humidex levels were computed based on the home's record of temperatures and humidity taken from June 30 to July 6, 2018, and the Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes, as referred to in the home's policy. The following humidex levels were noted on specified dates and locations, specifically as it relates to the cooling areas (dining rooms) being at uncomfortable levels:

June 30, 2018 - 0945hrs
3rd floor: North: 35 South: 35 Dining Room: 36
4th floor: South: 34 Dining Room: 33
5th floor: South: 36 Dining Room: 35
6th floor: North: 37 Dining Room: 37

July 1, 2018 - 0915hrs
2nd floor: North: 35 Dining Room: 34
3rd floor: North: 35 South: 34 Dining Room: 35

July 2, 2018 - 0845hrs
2nd floor: North: 37 South: 36 Dining Room: 35
3rd floor: North: 36 South: 34 Dining Room: 35

July 3, 2018 - 1020hrs
3rd floor: North: 31 South: 29 Dining Room: 30
4th floor: North: 29 South: 31 Dining Room: 31
5th floor: North: 31 Dining Room: 30
6th floor: South: 29 Dining Room: 30

July 4, 2018 - 1015hrs
3rd floor: North: 31 South: 31 Dining Room: 30
4th floor: North: 31 South: 31 Dining Room: 31
5th floor: North: 30 South: 30 Dining Room: 30

July 5, 2018 - 1030hrs
2nd floor: North: 33 Dining Room: 32
6th floor: North: 33 South: 32 Dining Room: 32

July 6, 2018 - 0930hrs
2nd floor: South: 30 Dining Room: 30
5th floor: North: 31 South: 31 Dining Room: 30
6th floor: North: 31 South: 31 Dining Room: 32

Observation of the air conditioners on the sixth floor dining room revealed that one of them were not functioning. DOC #106 confirmed this observation.

In an interview, Administrator #109 stated that the expectation related to designated cooling areas in the home is that they are kept cooler than other areas in the home. Administrator #109 acknowledged that on the above mentioned dates, times and locations, the dining rooms could not be considered cooling areas because they were not cooler than the other areas of the home; therefore, these floors did not have designated cooling areas available as required. [s. 20. (2)]

The severity of this issue was determined to be a level 2 as there was minimal harm, and potential for actual harm to the residents. The scope of the issue was a level 3 as it related to all residents. The home had a level 4 history as they had on-going noncompliance with this inspection of the LTCHA that included:

-written notification issued August 8, 2016 (2016_377502_0011);
-and compliance order issued October 27, 2017, with a compliance due date of

November 17, 2017 (2017_324535_0014).

Due to the severity, scope, and history, a compliance order and Director's Referral is warranted. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 07, 2018

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 Health and 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 18th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Babitha Shanmuganandapala

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