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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 8, 2018	2018_631210_0011	012538-18	Critical Incident System

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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 13, 14, and 15, 2018

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Care (ADOC), Registered Nurses, Personal Support Workers (PSW), Food Service Manager (FSM), Registered Dietitian (RD).

During the course of the inspection, the inspector observed staff and resident interactions, reviewed resident health records and relevant policies.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dining Observation
Hospitalization and Change in Condition
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home the dining and snack service that included at a minimum: providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to the unexpected death of resident #001. The CIS report indicated that on a specified date and time, resident #001 was noted by Personal Support Worker (PSW) #104 in a specific health condition. The resident was treated immediately, the Substitute Decision Maker (SDM) was notified, and resident was transferred to hospital with vital signs present. The resident passed away in hospital several hours after the transfer.

Interviews with Registered Practical Nurse (RPN) #105, PSW #103 and PSW #104 indicated that they were present in the dining room during the above mentioned incident involving resident #001. PSW #103 stated they were helping other residents with offering and serving the meal. RPN #105 reported they were in the dining room administering medications to a resident at another table then tried to help feed resident #001 with modified textured fluid but the resident refused. The RPN then proceeded to administer medications to other residents. Resident #001 did not have medications at that time. PSW #104 said the modified textured fluid was served on the table where resident #001 sat, and when offered assistance with feeding the resident refused. PSW #104 left the resident to independently consume the modified textured fluid from the cup in their hand and the spoon in their other hand. PSW #104 indicated they did not stay with the resident the whole time while they were feeding themself, but the PSW proceeded with serving other residents. When PSW #104 arrived at resident #001's table to offer food to resident #001's table-mate, resident #001 was in a specific health state and noted that the cup with modified textured fluid was empty on the table. According to staff #103, #104 and #105 the resident independently consumed the modified textured fluid and had not shown signs of distress.

A review of resident #001's clinical record indicated the resident was assessed by the Speech Language Pathologist (SLP) on two specified dates. The SLP recommended the following:
The first assessment indicated: The resident has suspected problem. To continue with current diet and modified textured fluid to decrease the risk of complications. The feeding precautions indicate specific instructions. Specific mouth hygiene is recommended after completing the meal.

The second assessment indicated: The resident is identified with an identified problem. The resident remains safest on a specific modified textured diet consistency with careful feeding techniques, to decrease risk of complications. Recommendations: continue the above mentioned modified textured diet, crushed medications, use a specific utensil only, requires one to one assist as resident not aware of problem. Staff to feed following specific instructions and observing while feeding. A review of the written plan of care revealed that the SLP recommendations for safe feeding techniques from the specified date, were transcribed by the registered nursing staff in the written plan of care, in the activity of daily living (ADL) section, eating subsection.

The nutrition section of the written plan of care was updated by the registered dietitian (RD) on a specified date, to include the resident's specified modified textured food and fluids.
Interview with the RD indicated that resident #001 was at high risk for a particular complication and someone should be with the resident the entire time while eating to make sure the written plan of care was followed. The RD stated they received a referral on a specified date, indicating resident #001 was assessed by SLP. The RD documented in the progress notes on the following day, indicating they updated the written plan of care with the appropriate diet. The RD followed up on the SLP recommendations few days later, and monitored the feeding of the resident during one meal. They observed that once staff finished feeding resident #001, the food and the plate were removed from the table. The resident was known to grab food placed on the table if they were not closely monitored. During an interview RD indicated that the feeding techniques in the ADL section for eating are supposed to be updated by the registered staff and it was not done. The RD confirmed that staff did not follow the SLP recommendations.

RPN #110 said that the expectation was that the nurse who was present during the SLP assessment should have processed the order and according to the level of risk if necessary to call the doctor on call. They should have verified the order if the RD was not in the home at that time and update the care plan. They confirmed that resident #001 was at high risk for a particular complication and the SLP assessment should have been implemented immediately.
Interview with RPN #105 indicated they sent a referral to the RD to process the order and update the care plan.
According to the RD the feeding techniques section of the SLP assessment should have been implemented by registered staff.

RPN #110 indicated that resident #001 required on-going monitoring while eating when

assisted by staff or independently eating. Staff should stay with the resident when eating to ensure safety.
A second interview with PSW #108 indicated they always stayed with the resident while eating. If the resident would display gestures that they wanted to eat independently, they would remind and assist the resident to eat safely and slowly.

Interview with the Administrator indicated that all new orders related to food and nutrition should be referred to the RD with collaboration from the registered staff and PSWs to make sure the care plan for residents is updated and implemented. Further, the Administrator indicated that the assessment from SLP is a recommendation and in order to be implemented it should be validated by the RD. They indicated that because the RD documented in the progress notes the registered staff considered it to be done and did not proceed to update the care plan. This was contradictory to RPN #110's interview statement mentioned above; they indicated that if a resident is at high risk for a particular complication, the registered staff should process the order by calling the physician on call if RD is not in the home to verify the order, and making sure it is implemented immediately.

Interview with Associate Director of Care (ADOC) #102 indicated resident #001 was at high risk for a particular complication and according to the SLP assessment and recommendations for safe feeding staff were not able to implement the plan of care if the resident was eating independently, and staff were performing other duties in the dining room. They acknowledged that the written plan of care was not updated according to the recommendations made by the SLP.

The resident sample was expanded to include resident #002 and #003 who required assistance with eating.
Observations were conducted on June 28, 2018, at dinner time, on two units.
During the observation on one unit it was noted that RPN #111 assisted resident #002 with feeding. The staff started using a specific utensil that was located on the table, and after two scoops of a specified modified textured fluid they changed to a different size or type of utensil.
A review of the written plan of care indicated resident #002 to sit in a specific position while feeding, use a specific utensil, give specific amount of food per mouthful and follow a specific procedure for safety.

During the meal observation it was noted that resident #003 was at the dining table. In front of them there was an empty plate of a modified textured diet with a specific utensil

in it. The dinner service was almost over and staff were collecting the plates from the tables.

The eating section of resident #003's written plan of care indicated that the resident required one staff total assistance with eating. The SLP assessment record indicated specific safe feeding instructions. An interview with resident #003's family member before the observation confirmed the feeding techniques and stated that the staff are aware of this.

During the observation of resident #003, PSWs #112, #113 and #114 were in the dining room and RPN #115 was administering medications to residents. During interviews staff were unable to confirm that resident #003 was assisted with eating. PSW #113 assisted the resident with the main course and then went to help another resident. PSW #112 served the dessert to resident #003 and expected that PSW #113 would feed the resident. PSW#112 confirmed that resident #003 requires total assistance with eating. During interviews PSW #112 reported that they did not assist resident #003 with the dessert. PSW #112 was not able to explain the feeding techniques for resident #003 and was not able to demonstrate to the Inspector how to open the written plan of care, because the tablet for electronic documentation was new for them. Interview with RPN #115 indicated staff should have assisted resident #003 with the dessert using a specific utensil. PSWs #112, #113, #114 and RPN #115 were unable to explain how resident #003 ate their dessert independently.

According to the interviews with staff #101, #102, #103, #104, #105, #106, #108 and #110, resident #001 was not provided with assistance to safely eat and drink on the above mentioned specified date, according to the recommendations contained in the SLP assessment.

Interview with Food Service Manager (FSM) #101 indicated resident #001 required one to one monitoring while they were eating for safety. Further, FSM stated that the staff should have provided assistance to residents #002 and #003 using a specific utensil. Resident #003 should be monitored one to one until completion of the meal, and staff did not follow the care plan for safe feeding techniques. [s. 73. (1) 9.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death resulting from an incident or suicide.

A CIS report was submitted to the MOHLTC related to the unexpected death of resident #001. The CIS report indicated that on a specified date and time, resident #001 was noted by Personal Support Worker (PSW) #104 in a specific health condition. The resident was treated immediately, the Substitute Decision Maker (SDM) was notified, and transferred to hospital with vital signs present. The resident passed away in hospital several hours after the transfer.

Interview with the Administrator indicated the incident was submitted to MOHLTC the next day after the incident. They did not report resident's death to MOHLTC immediately because the resident left the long-term care home with vital signs present and several hours later they passed away in hospital. The clinical record indicated the Charge Nurse documented in the progress notes that resident #001 passed away in hospital at a specific time. The Administrator and ADOC #102 stated that the expectation was the unexpected death was to be communicated with the manager on call, who would inform the MOHLTC immediately. [s. 107. (1)]

Issued on this 27th day of August, 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) :	SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2018_631210_0011
Log No. / No de registre :	012538-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 8, 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 :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lora Monaco

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. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79.10, r. 73. (1) 9.

The licensee shall prepare, submit and implement a plan to ensure that residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

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

The licensee to review and clarify the present process for implementing recommendations made by the Speech Language Pathologist (SLP) and review the role and responsibilities of registered staff, Personal Support Workers (PSWs) and Registered Dietitian (RD) as it related to the implementation of the SLP recommendations. The responsibilities should include but is not limited to who is responsible for updating the care plan with recommendations for all residents who are assessed by the SLP.

The licensee must create an auditing tool to make sure the care plans of all residents who require safe feeding techniques are updated and implemented.

All direct care staff including dietary aids, PSWs and registered staff are to be educated in the process for implementing recommendations made by the SLP and educated in safe feeding techniques. The home is required to maintain documentation of when the education occurred, the content of the education, who attended the education and who provided the education.

Please submit the written plan quoting inspection #2018_631210_0011 and Slavica Vucko by email to TorontoSAO.moh@ontario.ca by August 24, 2018.

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

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home the dining and snack service that included at a minimum: providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to the unexpected death of resident

#001. The CIS report indicated that on a specified date and time, resident #001 was noted by Personal Support Worker (PSW) #104 in a specific health condition. The resident was treated immediately, the Substitute Decision Maker (SDM) was notified, and resident was transferred to hospital with vital signs present. The resident passed away in hospital several hours after the transfer.

Interviews with Registered Practical Nurse (RPN) #105, PSW #103 and PSW #104 indicated that they were present in the dining room during the above mentioned incident involving resident #001. PSW #103 stated they were helping other residents with offering and serving the meal. RPN #105 reported they were in the dining room administering medications to a resident at another table then tried to help feed resident #001 with modified textured fluid but the resident refused. The RPN then proceeded to administer medications to other residents. Resident #001 did not have medications at that time. PSW #104 said the modified textured fluid was served on the table where resident #001 sat, and when offered assistance with feeding the resident refused. PSW #104 left the resident to independently consume the modified textured fluid from the cup in their hand and the spoon in their other hand. PSW #104 indicated they did not stay with the resident the whole time while they were feeding themself, but the PSW proceeded with serving other residents. When PSW #104 arrived at resident #001's table to offer food to resident #001's table-mate, resident #001 was in a specific health state and noted that the cup with modified textured fluid was empty on the table. According to staff #103, #104 and #105 the resident independently consumed the modified textured fluid and had not shown signs of distress.

A review of resident #001's clinical record indicated the resident was assessed by the Speech Language Pathologist (SLP) on two specified dates. The SLP recommended the following:
The first assessment indicated: The resident has suspected problem. To continue with current diet and modified textured fluid to decrease the risk of complications. The feeding precautions indicate specific instructions. Specific mouth hygiene is recommended after completing the meal.
The second assessment indicated: The resident is identified with an identified problem. The resident remains safest on a specific modified textured diet consistency with careful feeding techniques, to decrease risk of complications. Recommendations: continue the above mentioned modified textured diet, crushed medications, use a specific utensil only, requires one to one assist as resident not aware of problem. Staff to feed following specific instructions and

observing while feeding. A review of the written plan of care revealed that the SLP recommendations for safe feeding techniques from the specified date, were transcribed by the registered nursing staff in the written plan of care, in the activity of daily living (ADL) section, eating subsection.

The nutrition section of the written plan of care was updated by the registered dietitian (RD) on a specified date, to include the resident's specified modified textured food and fluids.
Interview with the RD indicated that resident #001 was at high risk for a particular complication and someone should be with the resident the entire time while eating to make sure the written plan of care was followed. The RD stated they received a referral on a specified date, indicating resident #001 was assessed by SLP. The RD documented in the progress notes on the following day, indicating they updated the written plan of care with the appropriate diet. The RD followed up on the SLP recommendations few days later, and monitored the feeding of the resident during one meal. They observed that once staff finished feeding resident #001, the food and the plate were removed from the table. The resident was known to grab food placed on the table if they were not closely monitored. During an interview RD indicated that the feeding techniques in the ADL section for eating are supposed to be updated by the registered staff and it was not done. The RD confirmed that staff did not follow the SLP recommendations.

RPN #110 said that the expectation was that the nurse who was present during the SLP assessment should have processed the order and according to the level of risk if necessary to call the doctor on call. They should have verified the order if the RD was not in the home at that time and update the care plan. They confirmed that resident #001 was at high risk for a particular complication and the SLP assessment should have been implemented immediately.
Interview with RPN #105 indicated they sent a referral to the RD to process the order and update the care plan.
According to the RD the feeding techniques section of the SLP assessment should have been implemented by registered staff.

RPN #110 indicated that resident #001 required on-going monitoring while eating when assisted by staff or independently eating. Staff should stay with the resident when eating to ensure safety.
A second interview with PSW #108 indicated they always stayed with the resident while eating. If the resident would display gestures that they wanted to

eat independently, they would remind and assist the resident to eat safely and slowly.

Interview with the Administrator indicated that all new orders related to food and nutrition should be referred to the RD with collaboration from the registered staff and PSWs to make sure the care plan for residents is updated and implemented. Further, the Administrator indicated that the assessment from SLP is a recommendation and in order to be implemented it should be validated by the RD. They indicated that because the RD documented in the progress notes the registered staff considered it to be done and did not proceed to update the care plan. This was contradictory to RPN #110's interview statement mentioned above; they indicated that if a resident is at high risk for a particular complication, the registered staff should process the order by calling the physician on call if RD is not in the home to verify the order, and making sure it is implemented immediately.

Interview with Associate Director of Care (ADOC) #102 indicated resident #001 was at high risk for a particular complication and according to the SLP assessment and recommendations for safe feeding staff were not able to implement the plan of care if the resident was eating independently, and staff were performing other duties in the dining room. They acknowledged that the written plan of care was not updated according to the recommendations made by the SLP.

The resident sample was expanded to include resident #002 and #003 who required assistance with eating.
Observations were conducted on June 28, 2018, at dinner time, on two units. During the observation on one unit it was noted that RPN #111 assisted resident #002 with feeding. The staff started using a specific utensil that was located on the table, and after two scoops of a specified modified textured fluid they changed to a different size or type of utensil.
A review of the written plan of care indicated resident #002 to sit in a specific position while feeding, use a specific utensil, give specific amount of food per mouthful and follow a specific procedure for safety.

During the meal observation it was noted that resident #003 was at the dining table. In front of them there was an empty plate of a modified textured diet with a specific utensil in it. The dinner service was almost over and staff were collecting the plates from the tables.

The eating section of resident #003's written plan of care indicated that the resident required one staff total assistance with eating. The SLP assessment record indicated specific safe feeding instructions. An interview with resident #003's family member before the observation confirmed the feeding techniques and stated that the staff are aware of this.

During the observation of resident #003, PSWs #112, #113 and #114 were in the dining room and RPN #115 was administering medications to residents. During interviews staff were unable to confirm that resident #003 was assisted with eating. PSW #113 assisted the resident with the main course and then went to help another resident. PSW #112 served the dessert to resident #003 and expected that PSW #113 would feed the resident. PSW#112 confirmed that resident #003 requires total assistance with eating. During interviews PSW #112 reported that they did not assist resident #003 with the dessert. PSW #112 was not able to explain the feeding techniques for resident #003 and was not able to demonstrate to the Inspector how to open the written plan of care, because the tablet for electronic documentation was new for them. Interview with RPN #115 indicated staff should have assisted resident #003 with the dessert using a specific utensil. PSWs #112, #113, #114 and RPN #115 were unable to explain how resident #003 ate their dessert independently.

According to the interviews with staff #101, #102, #103, #104, #105, #106, #108 and #110, resident #001 was not provided with assistance to safely eat and drink on the above mentioned specified date, according to the recommendations contained in the SLP assessment.

Interview with Food Service Manager (FSM) #101 indicated resident #001 required one to one monitoring while they were eating for safety. Further, FSM stated that the staff should have provided assistance to residents #002 and #003 using a specific utensil. Resident #003 should be monitored one to one until completion of the meal, and staff did not follow the care plan for safe feeding techniques.

The severity of this issue was determined to be a level 2 as there was potential for actual harm involving residents #001 and #003. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 4 history of on-going non-compliance with this section of the Act that included: Voluntary Plan of Correction (VPC) issued June 2016 and April 2016 [s. 73. (1)

9.] (210)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 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 8th day of August, 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 : Slavica Vucko

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