Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 21, 2020	2020_766500_0007 (A1)	004927-20, 007682-20, 008698-20, 015077-20, 015104-20, 015326-20, 015437-20	Complaint

Licensee/Titulaire de permis

Villa Colombo Seniors Centre (Vaughan) Inc.
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Villa Colombo Seniors Centre (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Amended by NITAL SHETH (500) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An amendment was made to WN #4 under regulation s. 229 (4).

Issued on this 21st day of October, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by NITAL SHETH (500) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 16, 17, 20, 21, 22, 23 (off-site), 24, 27, 28, 29, 30, 31, August 1 (off-site), 4, 5, 6, 10, 11, 12, 2020.

The following intakes were completed during this inspection:

Logs #004927-20 related to resident's care, #007682-20 related to Infection Prevention and Control (IPAC), #008022-20 related to declining of the resident's health status, #008698-20 related to palliative care of the resident , #013154-20 related to the home disclosing the information about the resident's health status, #015077-20, and #015104-20 related to duty to protect, and #015326-20 related to resident's care, 015437-20 related to IPAC.

This report includes non-compliances identified during following inspections which were completed concurrently:

-CIS inspection report #2020_766500_0008 under s. 221. (1) and r. 26. (4) (a),

-Complaint inspection report #2020_714673_0004 under r. 229 (4).

Inspection # 2020_714673_0004 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Interim Administrator, Corporate Clinical Manager, Assistant Director of Care (ADOC), Registered Dietitian (RD), Food Service Manager (FSM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), House-Keeper, Dietary Aide, Summer Student, the Residents and the Family Members.

During the course of the inspection, the inspector(s) observed the residents' care areas, meal services, and reviewed the residents' and the home's records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **11 WN(s)**
- **6 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home completed a nutritional assessment for residents #008, #022, #023, and #024 when there was a significant change in the residents'

health condition.

Review of resident #008's health records showed that they returned to the home from an admission to hospital. Progress notes showed that during the resident's hospitalization they were receiving a specified intervention due to the residents' health condition. Resident #008 passed away in the home as a result of health condition.

Review of the assessments tab in Point Click Care (PCC) showed Registered Dietitian (RD) referral was initiated on an identified day indicating that the resident returned from hospital with nutritional implications or a significant change in status. The referral was addressed by RD #113, indicating that the resident was discharged.

In an interview, the Interim Administrator #100 indicated that the home was without a permanent RD for a period of time and an RD from a local hospital conducted some assessments for residents in the home but only completed 11 hours of clinical services in the RD role. RD #113 began their employment with the home at the end of the same month. Resident #008 did not receive a nutritional assessment when there was a significant change in the resident's health condition. [s. 26. (4) (a), s. 26. (4) (b)]

2. The following non-compliances under r. 26 (4) (a) for residents #022, #023, and #024 were identified during inspection # 2020_766500_0008.

A Critical Incident System (CIS) report was submitted to the Director related to resident #022 involving a fall with injury, transfer to hospital, and significant change in status.

Review of the resident's Medicine Discharge Summary and Summary of Care Document from the hospital indicated that resident #022 had decreased oral intake.

A review of the laboratory test results indicated that resident #022's lab values were abnormal when discharged to the home from the hospital.

Review of resident #022's medical record indicated the resident experienced a decrease in oral intake and lab values were monitored daily while in hospital. It highlighted that the resident's intake should be monitored closely as they may

require additional intervention.

In an interview, evening Registered Practical Nurse (RPN) #124 stated they had initiated resident #022's re-admission to the home but had not seen this document. In an interview, day RPN #126 stated that they had seen the document but had not read it.

Review of Policy # NCM 03-01-017 titled Hydration Assessment and Management, dated January 1, 2020, stated that Registered nursing staff should automatically make a referral to the RD after any change in health status requiring hospitalization and/or a resultant new diagnosis and/or progression of a current diagnosis in order for the RD to re-assess the resident's nutrition and hydration status.

Review of the progress notes indicated that the resident returned to the home with a specified device, and treatment for altered skin integrity.

Review of the assessments tab in PCC showed an RD referral was initiated indicating that the resident returned from hospital with nutritional implications or a significant change in status. The referral additionally showed resident #022 had altered skin integrity, change in their health condition and poor intake. The referral was addressed by RD #113 after the resident deceased indicating that they had been discharged.

In an interview, Interim Administrator #100 indicated that the home was without a permanent RD for a period of time and an RD from a local hospital conducted some assessments for residents in the home but only completed 11 hours of clinical services in the RD role. RD #113 began their employment with the home at the end of the same month. Acting Administrator #100 acknowledged that resident #022 did not receive a nutritional assessment, nor was their hydration status and risks relating to hydration and altered skin integrity completed by a dietitian when there was a significant change in the resident's health condition. [s. 26. (4) (a)]

3. The sample of residents was expanded to include resident #023 and resident #024 as a result of non-compliances identified for resident #008 and #022.

Review of progress notes indicated that resident #023 was transferred to hospital

for assessment.

Resident #023 returned to the home with change in health condition.

In an interview, RD #113 stated they were still dealing with a back log of referrals from when they started their position, but they are normally able to address referrals within two to three days. RD #113 confirmed that they had received a referral for resident #023 but they had not yet completed the assessment.

In an interview, RPN #105 acknowledged that a dietitian assessment had not been completed for resident #023 following their hospitalization and return to the home after a significant change in their health status.

In multiple interviews throughout the inspection, RD #113 stated that they were dealing with a back log of referrals since they started working in the home. When asked what had been done to address the backlog, RD #113 stated that they were planning to address the issue with management that same day. A high level review of pending referrals for RD #113 indicated that there were 33 back log referrals. [s. 26. (4) (a)]

4. A review of resident #024's progress notes indicated that they were sent to hospital as a Personal Support Worker (PSW) had reported they had change in their condition. In hospital, they were returned to the home with treatment.

Review of Policy #NCM 03-01-017 titled Hydration Assessment and Management, dated January 1, 2020, stated that Registered nursing staff should automatically make a referral to the RD after any change in health status requiring hospitalization and/or a resultant new diagnosis in order for the RD to re-assess the resident's nutrition and hydration status.

Review of the assessments tab in PCC and progress notes did not show that a referral to a dietitian had been completed for resident #022 upon their return from the hospital. In an interview, RD #113 confirmed they had not received a referral for resident #024.

In an interview, RPN #105 stated that a referral to the dietitian should have been made for resident #024 due to their change in health status requiring hospitalization. RPN #105 confirmed that as a result, a dietitian assessment was not completed for resident #024 as required. [s. 26. (4) (a)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The MLTC received a complaint raising concerns with resident #006's care.

A review of CIS indicated an incident happened to resident #006. The resident reported that during transfer the staff member dropped the resident and caused pain in their various body parts. X-ray results indicated injury and the resident was transferred to the hospital.

A review of resident #006's plan of care indicated that the resident required total assistance for transferring by two people via a specified device.

An interview with RPN #112 confirmed that they did not use a specified device, and two people to transfer resident #006.

A review of the home's policy #02-01-08, entitled, "Zero Lift", dated April 2019, indicated that the staff are required to comply with the policies and procedure, to ensure resident and worker safety. The policy promotes to ensure applications of safe resident lift, transfer and repositioning techniques.

Interview with the Interim Administrator confirmed that the staff are required to use safe transferring and positioning devices and techniques when assisting residents.

This non-compliance was issued as a result of staff failure to use safe transferring devices and techniques when assisting the resident. [s. 36.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu substitutions were communicated to residents and staff.

The MLTC received a complaint regarding food preparation and food delivery. During the inspection, Inspector #673 received complaints from residents #027 and #029 regarding food quality and availability.

On August 4, 2020, Inspector #673 completed a dining observation during lunch time on a specified unit. Pineapple tidbits and tiramisu cream were observed to be served as dessert options.

Review of the menu posted on the unit indicated that the dessert options were to be mixed melons and cappuccino pudding.

In an interview, Food Service Manager (FSM) #141 stated that they could not find cappuccino pudding, so they had replaced it with tiramisu instead; however, they had not communicated the change to the residents or staff. [s. 72. (2) (f)]

2. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

In interviews, residents #027, #028 and #029 complained about the taste and

quality of the food on weekends.

In an interview, FSM #141 stated that they had started working in the home in May 2020, during which time the home was in a COVID-19 outbreak. During the outbreak, residents were provided food in clamshell (disposable) containers with plastic utensils and a paper napkin. The outbreak ended on June 6, 2020, and residents continued to be provided food in clamshell (disposable) containers with plastic utensils and a paper napkin on weekends. They stated that this was due to having a shortage of dietary aide staff on weekends. The home continued providing food to residents in clamshell (disposable) containers on weekends during this inspection.

FSM #141 stated that they had received multiple complaints from residents and families about the food. FSM #141 acknowledged that the quality of the food became poor when stored and served in the clamshell (disposable) containers, and that it did not look appealing or presentable.

Please refer to the grounds provided for Written Notification #6 issued pursuant to LTCHA, s. 71. (4). and Written Notification #7 issued pursuant to LTCHA, s. 73. (1) 6. [s. 72. (3) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all menu substitutions are communicated to residents and staff, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that there was a written record of the annual Infection Prevention and Control (IPAC) program evaluation kept that included a summary of the changes made, and the date those changes were implemented.

The MLTC received a complaint regarding infection prevention and control issues within the home.

A review of the home's IPAC program evaluation for 2019 showed that it did not include a summary of the changes made, and the date those changes were implemented.

In an interview, DOC #100 acknowledged that the annual IPAC program evaluation was incomplete. [s. 229. (2) (e)]

2. The licensee has failed to ensure that all staff participated in the IPAC program.

Observations by Inspector #643 showed that resident #009 was under isolation precautions according to signage posted on the resident's door. Signage was posted instructing staff on the process for donning and doffing Personal Protective Equipment (PPE). A caddy containing PPE was stationed outside the resident's door. Observations were conducted, Inspector #643 observed PSW #121 emerge from resident #009's room not wearing appropriate PPE. There were one surgical mask and zero gowns found inside the caddy; a box of gloves was found on top of the caddy.

Review of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued June 10, 2020, showed all new residents who have not been previously cleared of COVID-19 must remain in isolation for a 14-day period following arrival.

Review of resident #009's health records indicated that they were admitted to the home and had resided in the home for 12 days at the time of the observation. Resident #009's records showed they had tested negative for COVID-19 prior to being transferred back to the home and had not been cleared of COVID-19.

In an interview, PSW #121 indicated that they had gone to assist resident #009 and did not have the supplies in the PPE caddy outside the resident room and did not use appropriate PPE before approaching the resident to provide care. PSW #121 indicated that they should be using appropriate PPE prior to providing care to resident #009.

In an interview, RPN #120 indicated that they were aware that resident #009 was on isolation precautions and staff were required to use appropriate PPE prior to providing care. RPN #120 indicated that staff should approach them if running low on PPE supplies in the caddy outside of the resident room and can re-stock from the nursing station or ask the facility charge nurse for more supplies. RPN #120 indicated that staff did not approach them to restock the PPE supplies on the unit.

In an interview, Assistant Director of Care (ADOC) #122 indicated that it was the expectation of the home for staff to request additional supplies from the nurse on the unit, who would get the required supplies from the nursing station. ADOC #122 indicated that when a unit was running low on supplies, they would need to request them from the facility charge nurse to restock. ADOC acknowledged that as Personal Support Worker (PSW) #121 approached resident #009 to provide care without appropriate PPE that they failed to participate in the home's infection prevention and control program. [s. 229. (4)]

3. The MLTC received a complaint regarding infection prevention and control issues within the home.

a) On July 16, 2020, at approx. 1405hrs, a family member wearing full PPE (gown, mask, gloves, goggles) was observed in a hallway leading towards the entrance of the home, outside the resident units. The family member asked Inspector #673 where to take off the PPE and whether it was to be taken off at the

entrance. Inspector #673 redirected them back to the resident room they had come from. Notices on the door of the room indicated that the resident the visitor had seen was on isolation. Inspector #672 inquired whether a staff member was nearby to help them. No staff member was observed in the vicinity. PSW #127 was later seen coming down the hall to assist the family member but was observed to not be wearing a mask. In an interview, PSW #127 acknowledged that they should have been wearing a mask in resident care areas and that the visitor should have been given adequate instructions regarding doffing of PPE before exiting the room.

b) On July 16, 2020, Administrator #101 informed the inspection team that a mask and a face shield/goggles are required to be worn by all staff including inspectors when in resident care areas/units, and masks are to be worn at all other times.

Review of a COVID-19 update on daily procedure mask use, dated June 19, 2020, titled Eye Protection Instructions- COVID-19 stated that extended use of eye protection (Goggles or Face Shield) is required for the full duration of the shift.

Inspector #673 made the following observations on July 17, 2020:

- At approximately 1335hrs, housekeeper #128 was observed on a resident unit without goggles or face shield and could not clearly articulate what the home's policy related to PPE was.

-At approximately 1345hrs, PSW #129 was observed sitting at the nursing station on a resident care unit with their mask on their chin and not covering their nose or mouth.

- At approximately 1352 hrs, agency PSW #130 was observed without a face shield/goggles and only a mask. PSW #130 stated they had stopped wearing the face shield one week ago when they forgot to bring it to work. PSW #130 stated they were unaware that the home's policy required them to wear it in resident care areas.

- At 1406 hrs, PSW #131 was observed wearing their goggles on their head in a resident care area and standing near a resident. Upon inquiry of the home's policy related to PPE by Inspector #673, PSW #131 cleaned it and donned the goggles appropriately.

- At approximately 1410 hrs, housekeeper #132 was observed wearing their goggles on the back of their head. Upon inquiry by Inspector #673, they stated that they thought that the home's policy only required them to wear the goggles inside resident rooms.

- At approximately 1412 hrs, Inspector #673 observed resident #025 with respiratory symptoms, touching doorknobs in the hallway and could not identify their name or their room when asked. Inspector #673 guided resident away from entering another resident's room and asked them to wait until a staff member could come to assist. Approx. 3-4 minutes later, PSW #133 guided resident #025 back to their room. Resident #025's room door had a sign indicating that they were in isolation. PSW #133 stated that the resident was in isolation as they were a new admission and that staff had just found out that residents are required to remain in isolation for two weeks, not two days, upon admission if they hadn't been cleared for COVID-19. PSW #133 was observed to with inappropriate PPE while they guided resident #025 back into their room.

-At approximately 1420 hrs, agency PSW #134 was observed to have come out of a resident room. PSW #134 stated that they had just finished providing assistance to a nurse with wound care for a resident. PSW #134's mask was falling off their face and was noted to not have been sealed at the bridge of the nose.

- At 1440 hrs, agency PSW #135 was observed walking out of room the resident's room with their mask hanging off one ear. When Inspector #673 asked about the mask, they stated that they had been eating a yogurt in the resident's room. PSW #135 proceeded back into the room and continued to eat their yogurt. PSW #135 acknowledged that they should not be eating in the resident's room, and that they should be wearing their mask appropriately.

-At approximately 1520 hrs, two staff members were observed on a resident unit. One staff member had just a mask on and PSW #136, had their goggles on top of their mask. Upon questioning about the home's policy regarding PPE, PSW #136 took them off their mask and put them on their eyes. PSW #136 acknowledged that the home's expectation was for masks and face shields/goggles to be worn at all times in resident care areas.

At the end of the day on July 17, 2020, Inspector #673 informed Administrator #101 of their observations due to the level of risk related to IPAC issues during a

pandemic. On July 20, 2020, Inspector #673 was informed by DOC #100 that education had been provided to staff over the course of the last three days. DOC #100 acknowledged the inconsistency in messaging and practice of the home's expectations/policies related to staff wearing PPE in the home.

c) On July 21, 2020, at approximately 1221 hrs, RPN #105 was observed to be assisting one resident, then cleaning the tables of other residents and dumping dining utensils into water and putting them away. RPN #105 was observed to then proceed back to the initial resident and assisted them again without performing hand hygiene. In an interview, RPN #105 acknowledged that hand hygiene should have been performed after cleaning and prior to assisting the resident.

On August 4, 2020, at 1115 hrs, summer student #137 was observed next to resident #026 with some PPE on. Signs on the door of the room indicated that the residents inside were on isolation and staff were required to wear appropriate PPE. Summer student #137 was observed exiting the room and not performing hand hygiene until reminded to do so by the inspector.

On August 10, 2020, at 1400 hrs, housekeeper #138 was observed exiting a resident room after cleaning. Housekeeper #138 was wearing double gloves, the inner glove was ripped, and they performed hand hygiene with hand sanitizer onto the outer gloves. Housekeeper #138 was also observed taking off their PPE with their gown being removed before gloves (contrary to signs on door of steps on how to remove PPE), and taking off gloves using an incorrect technique. Housekeeper #138 stated that they had received training in PPE donning and doffing and IPAC, and that they wore two gloves as the hand sanitizer made their hands sticky.

On August 11, 2020, at 1624 hrs, Inspector #673 was at the nursing station and observed a staff member ask RPN #139 to help resident #026 make a phone call. Resident #026 was a new admission and was on isolation and was not observed to be wearing any PPE. Inspector #673 informed RPN #139 that resident #026 is supposed to be on isolation to which they responded that they were aware, but the resident would not remain in isolation due to their behaviour. Inspector #673 inquired whether there was an alternative way to help resident #026 make their phone call and suggested using the cordless phone in their room. RPN #139 did not respond, proceeded to help resident #026 make a phone call across from the nursing station where Inspector #673 was seated. While resident #026 was on the phone, they had some respiratory symtpoms, sending droplets all over the

table and documents. RPN #139 attempted to wipe down table.

In an interview, Interim Administrator #100 acknowledged that staff were not participating in the implementation of the infection prevention and control program. [s. 229. (4)]

4. The following noncompliance for resident #003 issued under O. Reg. 79/10, s. 229 (4) was identified in inspection #2020_714673_0004, which was completed concurrently.

The MLTC received a complaint regarding IPAC issues within the home.

The complainant provided audio recordings to the inspector. In a recording, the complainant is heard showing and explaining to PSW #117 how they wear double gloves when visiting the home. PSW #117 did not respond to correct the complainant's practice.

In an interview, PSW #117 stated that wearing double gloves is not best practice and that if a family member were to wear double gloves, it would be the responsibility of the home's staff to correct and educate the family member in order to protect the residents.

In an interview, Interim Administrator #100 acknowledged that staff were not participating in the implementation of the infection prevention and control program. [s. 229. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

Ministry of Long-term Care (MLTC) received a complaint raising concerns related to resident #005's care.

(i) A review of resident #005's progress notes indicated that resident #005 was transferred to the hospital and return to the home with a change in their health condition.

A review of resident #005's clinical records indicated that a referral was sent to the RD, 10 days post hospitalization, for the resident returned from the hospital with nutritional implications or significant changes in health status as well as the resident had difficulties in eating. The RD completed an assessment for this referral 14 days later of receiving a referral, after being notified by Interim Administrator #100, to complete the referral as a result investigating on the family's concerns regarding the resident's care.

Interview with RPN #112 indicated that they need to send a referral to the RD on the same day the resident returned from the hospital.

Interview with RD #113 indicated that they need to receive a referral when a resident returns from a hospital with a significant change in their health status to address the risk related to nutrition and hydration.

(ii) Review of resident #005's progress notes indicated that the resident's private care giver reported the resident identified with a new altered skin integrity. The referral to Registered Dietitian (RD) was sent the next day to assess the resident for altered skin integrity.

A review of copies of emails provided by the DOC indicated that the DOC sent an email 16 days later, to the RD that the family was concerned about the resident as the resident was having poor intake after return from the hospital. The DOC informed the RD that two referrals sent to the RD were not completed.

A review of assessments and progress notes indicated that the RD assessed the resident after reported by the DOC.

A review of the home's policy #03-01-01, entitled, "Nutrition Care and Hydration Program Overview", dated July 2011, indicated that the RD to assess the resident when the resident's needs change.

A review of the home's policy #NUR 02-05-01, entitled, "Skin Integrity Program Overview", dated January 01, 2020, indicated that RD to assess the resident with impaired skin integrity and outline interventions related to nutrition and hydration. The RD will calculate accurate individual calorie needs and recommend protein/vitamins required for proper healing and follow the resident regularly.

Interview with RD indicated that usually they need to complete a referral within 3 days of the date of receiving due to address nutrition and hydration risk to the resident.

This non-compliance was issued as a result of the licensee failure to collaborate with RD when the resident returned from a hospital with a significant change in their health status. [s. 6. (4) (a)]

2. A complaint was submitted to the MLTC regarding the nutrition and hydration care of resident #008. The complainant alleged that staff had not provided the appropriate level of assistance with eating and drinking for the resident in two months. The complainant indicated that the resident had experienced weight change and was hospitalized due to change in their health condition.

Review of resident #008's health records showed that the resident required total assistance for eating from staff. The records showed that over a three-day period, the resident consumed fluid below their estimated fluid requirement.

In interviews, PSWs #116, #117 and #118 indicated that resident #008 had been refusing to eat and drink at times when staff attempted to assist them with eating and drinking. The PSW staff indicated that they would re-approach the resident and make further attempts to assist them. The PSW staff indicated that resident #008 would consume fluid at meals and they would document the fluid servings in point of care (POC) documentation.

The RPN indicated that when a resident had poor fluid intake that a referral would be initiated to have the RD assess the resident. RPN #119 did not know if there was a certain level of fluid intake that should trigger a referral to the RD for poor fluid intake.

RPN #105 indicated they would initiate an RD referral when a resident misses 2 or more meals. RPN #105 additionally indicated that if noting signs or symptoms of dehydration in a resident they would refer to the physician and that resident #008 was not exhibiting signs or symptoms of dehydration.

Review of resident #008's assessments and progress notes in PCC showed that a referral was completed to the RD related to the resident's difficulty in eating and change in their weight. The referral document did not indicate the resident had poor fluid intake observed. RD #124 completed an assessment of resident #008's

nutrition status but did not review the resident's hydration status at the time.

Review of the home's policy titled "Hydration Program" policy #03-01-012, last reviewed January 2014 showed that registered staff were responsible for calculating a resident's fluid intake every 24 hours. When a resident has fluid intake below their established goal for several days or altered fluid intake from their usual pattern a referral to the RD must be completed.

In an interview, Interim Administrator #100 indicated that when a resident is consuming less than 50% of their fluid requirement in a day Registered staff would need to assess the resident and push fluids. The Interim Administrator additionally indicated that when a resident's fluid intake was lower than their usual pattern over a pattern of three days, it was the expectation that a referral be sent to the RD for assessment. The Interim Administrator acknowledged that as resident #008 had a change in their usual fluid intake, a referral to the RD should have been carried out for assessment of the resident's hydration status. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care.

The MLTC received a complaint raising concerns with resident #006's care.

A review of the CIS indicated an incident happened to resident #006. The resident reported that during transfer the staff member dropped the resident and caused injury. X-ray results indicated an injury. The resident was transferred to the hospital.

A review of resident #006's plan of care indicated that the resident required total assistance for transferring by two people via a specified device.

An interview with RPN confirmed that after the incident, they checked the resident's plan of care, and found that the resident required a specified device. RPN #112 indicated that they assisted the resident without checking their plan of care. RPN #112 confirmed that they are expected to follow the resident's plan of care.

Interview with Interim Administrator #100 confirmed that staff are expected to be aware of the resident's plan of care and able to implement it.

This non-compliance was issued as a result of staff failure to be aware of the content of the resident's plan of care. [s. 6. (8)]

4. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

MLTC Inspector# 665, received a concern from the complainant that the home did not manage resident #004's pain well.

A review of the resident's progress notes indicated that resident #004 was observed with pain. The doctor was called and given order for pain medication every two hours as needed. The medication was administered as per the order and was effective at this time.

A review of the medication administrator record indicated that the resident was administered pain medication which was not effective on six occasions.

A review of the home's policy #02-04-07, entitled, "Palliative Care Program", dated July 2010, indicated that the Palliative Care Program provides relief from pain, and other distressing symptoms, provide care and medical treatment to ensure comfort of the resident. Registered staff to monitor pain level and administer medications as order. The nursing staff will work to alleviate pain.

A review of the home's policy #RC 06-01-09, entitled, "Pain Management", dated December 30, 2019, indicated that if the interventions have not been effective in managing pain, initiate alternative approaches, and consider referral to a palliative care team, and or symptom management consultant for pain that is not well controlled.

Interview with RPN #105 and Interim Administrator #100 acknowledged that when pain management interventions are not effective, then they need to inform the physician.

This non-compliance was issued as a result of staff failure to reassess the resident, and to review and revise the plan of care when, care set out in the plan had not been effective. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that,
- the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other,
- the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care,
- that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal.

The MLTC received a complaint regarding food preparation and food delivery. During the inspection, Inspector #673 received complaints from residents #027 and #029 regarding food quality and availability.

In interviews, resident #027 and Dietary Aide #142 stated that on weekends, residents were not being provided with soup during lunch and that they were not being offered choices for entrees, vegetables or desserts at lunch and dinner. Resident #027 further stated that the portion sizes were smaller, and the food was not enough for them.

Dietary Aide #142 stated that each unit was being provided with six extra sandwiches but acknowledged that this was not enough for all residents to have a second choice, nor was it part of the planned menu items.

Review of the spring/summer 2020 menu provided by Food Service Manager #141 indicated soup was to be served during lunch on weekends, and included choices to be offered for entrees, vegetables and desserts at lunch and dinner.

In an interview, FSM #141 acknowledged that the planned menu items were not being offered or available during lunch and dinner on the weekends. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal, to be implemented voluntarily.

WN #7: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids were served at a temperature that is both safe and palatable to the residents.

In interviews, residents #027 and #029 complained about the taste, quality and temperature of the food on weekends.

In interviews, resident #027, Dietary Aide #142 and FSM #141 stated that residents were being provided food in clamshell (disposable) containers on the weekends. Dietary Aide #142 and Food Service Manager #141 stated this was due to short staffing of dietary aides on weekends. FSM #141 further stated that due to this issue, the food was being prepared and stored in clamshell (disposable) containers and sent to each unit where the PSWs were to take them and serve them to residents. FSM #141 acknowledged that as the boxes were not insulated, the food was probably becoming cold before they were served. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the daily and weekly menus are communicated to residents and
- the home has a dining and snack service that includes, at a minimum, the following elements: food and fluids being served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under s. 76 (2) receive retraining in Infection Prevention and Control (IPAC), the areas mentioned in the subsection at times or at intervals provided for in the regulations.

Review of the home's training compliance documents for IPAC and hand hygiene indicated that 90% of staff completed the training in 2019. Review of the home's training compliance documents for infection prevention/hand washing indicated that 92% of staff completed the training.

In an interview, Interim Administrator #100 stated that agency staff had not received training in IPAC in 2019.

This noncompliance was issued as a result of the licensee failing to provide training to agency staff in 2019. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the persons who have received training under s. 76 (2) receive retraining in Infection Prevention and Control (IPAC), the areas mentioned in the subsection at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training was provided to all staff who provide direct care to residents: Falls Prevention and Management and Skin and Wound Care.

A review of the home's training records for the above-mentioned programs did not include agency staff working in the home for 2019.

Interview with Interim Administrator #100 indicated that the home does not have agency staff training records for the above-mentioned programs for 2019.

This non-compliance was issued as a result of the licensee failing to provide required education to the agency staff. [s. 221. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training are provided to all staff who provide direct care to residents:
- Falls Prevention and Management,
- Skin and Wound Care, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

The MLTC received a complaint regarding food preparation, food delivery and cleanliness. During the inspection, Inspector #673 received complaints from residents #027 and #029 regarding food quality, availability and cleanliness.

In an interview, resident #027 stated that the dining area and tables were not clean on weekends as no one was cleaning them.

In an interview, FSM #141 stated that they had received multiple complaints from families that the tables were not cleaned; however, they were not aware that residents were going to the dining room on weekends when they were being served food in clamshell (disposable) containers. FSM #141 stated that this was the responsibility of the dietary aides; however, this was not being done as they were short staffed of dietary aides on the weekends. [s. 15. (2) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006 was free from neglect by RPN #112.

For the purposes of the Act and this Regulation, “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.

A review of CIS indicated an incident related to staff to resident neglect. The resident reported that during transfer the staff member dropped the resident and caused pain. X-ray results indicated an injury. The resident was transferred to the hospital. The resident passed away in the hospital. The CIS report was first submitted to the MLTC four days later.

An interview with RPN #112 indicated that the resident requested them to assist with a specified care. RPN #112 assisted the resident and while transferring the resident, they had to land the resident on the floor. RPN #112 called the PSW and they both transferred the resident to the bed using a specified device. The resident complained about pain after a few minutes and RPN #112 provided pain medication to the resident. RPN #112 confirmed that they were not sure if they required to report and document this incident, and therefore, they search the internet and decided not to report and document the incident.

A review of the home’s investigation notes indicated that RPN #112 neglected resident #006, and placed them at risk for further injuries, pain and suffering. RPN #112, withheld resident’s assessment and treatment, failed to document the incident report, reporting to the family, attending physician, and health care team.

Interview with Interim Administrator #100 confirmed that as a result of neglect disciplinary actions were implemented to RPN #112.

This non-compliance is additional evidence to the Compliance Order (CO) #002, issued under s. 19 (1)., during inspection # 2019_766500_0032 (A2) dated June 12, 2020. This non-compliance was issued as a result of the licensee failing to protect the resident from neglect. [s. 19. (1)]

Issued on this 21st day of October, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by NITAL SHETH (500) - (A1)
Inspection No. / No de l'inspection :	2020_766500_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	004927-20, 007682-20, 008698-20, 015077-20, 015104-20, 015326-20, 015437-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 21, 2020(A1)
Licensee / Titulaire de permis :	Villa Colombo Seniors Centre (Vaughan) Inc. 10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0
LTC Home / Foyer de SLD :	Villa Colombo Seniors Centre (Vaughan) 10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sherry Braic

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Villa Colombo Seniors Centre (Vaughan) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 26. (4) of O.Reg 79/10.
Specifically, the licensee must:
1. Ensure that for residents #023, and #024, who have significant changes in their health condition, Registered staff in the home complete a referral to the Registered Dietitian(s) for assessment;
2. Ensure that referrals to the Registered Dietitian(s) regarding a significant change to a resident's health condition are prioritized and addressed in a timely manner to assess nutritional and hydration status and risks and review and revise the resident's plan of care for nutrition and hydration;
3. Provide education to all Registered staff and Registered Dietitian(s) in the home on what constitutes a significant change in a resident's health status and the home's policies for when a resident has a significant change in their health status; and
4. Maintain a record of training provided including the materials presented, dates of training, and staff attendance records.

Grounds / Motifs :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home completed a nutritional assessment for residents #008, #022, #023, and #024 when there was a significant change in the residents' health condition.

Review of resident #008's health records showed that they returned to the home from an admission to hospital. Progress notes showed that during the resident's hospitalization they were receiving a specified intervention due to the residents' health condition. Resident #008 passed away in the home as a result of health condition.

Review of the assessments tab in Point Click Care (PCC) showed Registered Dietitian (RD) referral was initiated on an identified day indicating that the resident returned from hospital with nutritional implications or a significant change in status. The referral was addressed by RD #113, indicating that the resident was discharged.

In an interview, the Interim Administrator #100 indicated that the home was without a permanent RD for a period of time and an RD from a local hospital conducted some assessments for residents in the home but only completed 11 hours of clinical services in the RD role. RD #113 began their employment with the home at the end of the same month. Resident #008 did not receive a nutritional assessment when there was a significant change in the resident's health condition. (643)

2. The following non-compliances under r. 26 (4) (a) for residents #022, #023, and #024 were identified during inspection # 2020_766500_0008.

A Critical Incident System (CIS) report was submitted to the Director related to resident #022 involving a fall with injury, transfer to hospital, and significant change in status.

Review of the resident's Medicine Discharge Summary and Summary of Care Document from the hospital indicated that resident #022 had decreased oral intake.

A review of the laboratory test results indicated that resident #022's lab values were abnormal when discharged to the home from the hospital.

Review of resident #022's medical record indicated the resident experienced a decrease in oral intake and lab values were monitored daily while in hospital. It

highlighted that the resident's intake should be monitored closely as they may require additional intervention.

In an interview, evening Registered Practical Nurse (RPN) #124 stated they had initiated resident #022's re-admission to the home but had not seen this document. In an interview, day RPN #126 stated that they had seen the document but had not read it.

Review of Policy # NCM 03-01-017 titled Hydration Assessment and Management, dated January 1, 2020, stated that Registered nursing staff should automatically make a referral to the RD after any change in health status requiring hospitalization and/or a resultant new diagnosis and/or progression of a current diagnosis in order for the RD to re-assess the resident's nutrition and hydration status.

Review of the progress notes indicated that the resident returned to the home with a specified device, and treatment for altered skin integrity.

Review of the assessments tab in PCC showed an RD referral was initiated indicating that the resident returned from hospital with nutritional implications or a significant change in status. The referral additionally showed resident #022 had altered skin integrity, change in their health condition and poor intake. The referral was addressed by RD #113 after the resident deceased indicating that they had been discharged.

In an interview, Interim Administrator #100 indicated that the home was without a permanent RD for a period of time and an RD from a local hospital conducted some assessments for residents in the home but only completed 11 hours of clinical services in the RD role. RD #113 began their employment with the home at the end of the same month. Acting Administrator #100 acknowledged that resident #022 did not receive a nutritional assessment, nor was their hydration status and risks relating to hydration and altered skin integrity completed by a dietitian when there was a significant change in the resident's health condition. (500)

3. The sample of residents was expanded to include resident #023 and resident #024 as a result of non-compliances identified for resident #008 and #022.

Review of progress notes indicated that resident #023 was transferred to hospital for assessment.

Resident #023 returned to the home with change in health condition.

In an interview, RD #113 stated they were still dealing with a back log of referrals from when they started their position, but they are normally able to address referrals within two to three days. RD #113 confirmed that they had received a referral for resident #023 but they had not yet completed the assessment.

In an interview, RPN #105 acknowledged that a dietitian assessment had not been completed for resident #023 following their hospitalization and return to the home after a significant change in their health status.

In multiple interviews throughout the inspection, RD #113 stated that they were dealing with a back log of referrals since they started working in the home. When asked what had been done to address the backlog, RD #113 stated that they were planning to address the issue with management that same day. A high level review of pending referrals for RD #113 indicated that there were 33 back log referrals. (500)

4. A review of resident #024's progress notes indicated that they were sent to hospital as a Personal Support Worker (PSW) had reported they had change in their condition. In hospital, they were returned to the home with treatment.

Review of Policy #NCM 03-01-017 titled Hydration Assessment and Management, dated January 1, 2020, stated that Registered nursing staff should automatically make a referral to the RD after any change in health status requiring hospitalization and/or a resultant new diagnosis in order for the RD to re-assess the resident's nutrition and hydration status.

Review of the assessments tab in PCC and progress notes did not show that a referral to a dietitian had been completed for resident #022 upon their return from the hospital. In an interview, RD #113 confirmed they had not received a referral for resident #024.

In an interview, RPN #105 stated that a referral to the dietitian should have been made for resident #024 due to their change in health status requiring hospitalization. RPN #105 confirmed that as a result, a dietitian assessment was not completed for resident #024 as required.

The severity of this issue is a level 3 (actual harm), the scope was a level 3 (widespread), as it related to four out of four residents reviewed and compliance history was level 2 (previous non-compliance to a different subsection). (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of the O. Reg. 79/10, s.36. Specifically, the licensee must do the following:

1. Identify all residents that require the use of a mechanical lift and sit to stand lifts along with the specific sling to be used for transfer purposes on the identified unit and review their written plans of care with staff who provide direct care on this home area.
2. Implement an auditing system to ensure that direct care staff assist residents with transferring using the safe transferring techniques and devices which are included in the resident's plan of care.
3. Maintain records of the audits including but not limited to the resident name, date of audit, result of audit, and any corrective action taken as a result of the audits.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The MLTC received a complaint raising concerns with resident #006's care.

A review of CIS indicated an incident happened to resident #006. The resident reported that during transfer the staff member dropped the resident and caused pain in their various body parts. X-ray results indicated injury and the resident was transferred to the hospital.

A review of resident #006's plan of care indicated that the resident required total assistance for transferring by two people via a specified device.

An interview with RPN #112 confirmed that they did not use a specified device, and two people to transfer resident #006.

A review of the home's policy #02-01-08, entitled, "Zero Lift", dated April 2019, indicated that the staff are required to comply with the policies and procedure, to ensure resident and worker safety. The policy promotes to ensure applications of safe resident lift, transfer and repositioning techniques.

Interview with the Interim Administrator confirmed that the staff are required to use safe transferring and positioning devices and techniques when assisting residents.

This non-compliance was issued as a result of staff failure to use safe transferring devices and techniques when assisting the resident.

The severity of this issue is a level 3 (actual harm), the scope was a level 1 (isolated), as it related to one out of three residents reviewed and compliance history was level 3 (previous non-compliance to the same subsection) that included:
- Voluntary Plan of Action (VPC) and Written Notification (WN) issued during Inspection # 2019_631210_0011, dated July 12, 2019
- Compliance Order (CO) and Written Notification (WN) issued during Inspection # 2017_420643_0019, dated November 16, 2017. (500)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 18, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be compliant with s. 72. (3) of O. Reg 79/10.
Specifically, the licensee must ensure the nutrition care and dietary services program:
1. Serves food and fluids in appropriate dishware to preserve taste, nutritive value, appearance and food quality, at a temperature that is safe and palatable to residents, including on weekends. Exceptions may apply in the circumstances that disposable dishware items are required or recommended e.g. outbreak situations, emergency situations.
2. (i) Provide the planned portions of soups at lunch and other food and fluid items as per the planned menu at all meals and snacks,
(ii) Provide the planned choices for entrees, vegetables and desserts at meals and snacks as per the planned menu, to ensure that residents do not go to bed hungry on any days.
3. Review staffing levels in the Dietary Department and ensure appropriate staffing levels are maintained for all shifts;
4. Conduct audits of meal service including on Saturday and Sunday to ensure that:
(i) foods and fluids at a temperature that is safe and palatable to the residents
(ii) foods and fluids are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality;
5. Maintain record of audits conducted documenting the date of the audit, meal audited, unit audited, menu items served, resident satisfaction with meal service and name of the person completing the audit.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

In interviews, residents #027, #028 and #029 complained about the taste and quality of the food on weekends.

In an interview, FSM #141 stated that they had started working in the home in May 2020, during which time the home was in a COVID-19 outbreak. During the outbreak, residents were provided food in clamshell (disposable) containers with plastic utensils and a paper napkin. The outbreak ended on June 6, 2020, and residents continued to be provided food in clamshell (disposable) containers with plastic utensils and a paper napkin on weekends. They stated that this was due to having a shortage of dietary aide staff on weekends. The home continued providing food to residents in clamshell (disposable) containers on weekends during this inspection.

FSM #141 stated that they had received multiple complaints from residents and families about the food. FSM #141 acknowledged that the quality of the food became poor when stored and served in the clamshell (disposable) containers, and that it did not look appealing or presentable.

Please refer to the grounds provided for Written Notification #6 issued pursuant to LTCHA, s. 71. (4). and Written Notification #7 issued pursuant to LTCHA, s. 73. (1) 6.

The severity of this issue is a level 1 (minimal harm or minimal risk), the scope was a level 3 (widespread), and compliance history was level 2 (previous non-compliance to a different subsection). (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 20, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 229. (4) of the O. Reg. 79/10, s. 229 (4). Specifically, the licensee must do the following:

1. Provide clear direction to all staff for appropriate use of Personal Protective Equipment (PPE) for the residents who are on isolation, while working in the residents' care areas and in common areas of the home.
2. Ensure that each residents' areas have enough supply of PPE, and staff are aware where to obtain PPE if there is any shortage of PPE on the floors.
3. Develop and implement a system to ensure that each residents' areas have enough supply of PPE
4. Ensure that staff are aware of the type of PPE to be used and to use them in an appropriate manner
5. Train IPAC Champions on each unit to support the use of PPEs.
6. Ensure that all staff perform hand hygiene in between tasks during the residents' care and during all meal times
7. Develop and implement strategies to fulfill the residents' needs in their rooms during isolation to maintain their isolation
8. Develop and implement strategies to manage the residents' behaviour to maintain their isolation
9. Implement an auditing system to ensure that all staff from all departments (nursing, dietary, housekeeping, maintenance, staff on contracted services and management) participate in the implementation of Infection Prevention and Control (IPAC) program.
10. Maintain records of the audits including but not limited to the resident name, date of audit, result of audit, and any corrective action taken as a result of the audits.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the IPAC program.

Observations by Inspector #643 showed that resident #009 was under isolation precautions according to signage posted on the resident's door. Signage was posted instructing staff on the process for donning and doffing Personal Protective Equipment (PPE). A caddy containing PPE was stationed outside the resident's door. Observations were conducted, Inspector #643 observed PSW #121 emerge from resident #009's room not wearing appropriate PPE. There were one surgical mask and zero gowns found inside the caddy; a box of gloves was found on top of the caddy.

Review of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued June 10, 2020, showed all new residents who have not been previously cleared of COVID-19 must remain in isolation for a 14-day period following arrival.

Review of resident #009's health records indicated that they were admitted to the home and had resided in the home for 12 days at the time of the observation. Resident #009's records showed they had tested negative for COVID-19 prior to being transferred back to the home and had not been cleared of COVID-19.

In an interview, PSW #121 indicated that they had gone to assist resident #009 and did not have the supplies in the PPE caddy outside the resident room and did not use appropriate PPE before approaching the resident to provide care. PSW #121 indicated that they should be using appropriate PPE prior to providing care to resident #009.

In an interview, RPN #120 indicated that they were aware that resident #009 was on isolation precautions and staff were required to use appropriate PPE prior to providing care. RPN #120 indicated that staff should approach them if running low on PPE supplies in the caddy outside of the resident room and can re-stock from the nursing station or ask the facility charge nurse for more supplies. RPN #120 indicated that staff did not approach them to restock the PPE supplies on the unit.

In an interview, Assistant Director of Care (ADOC) #122 indicated that it was the expectation of the home for staff to request additional supplies from the nurse on the

unit, who would get the required supplies from the nursing station. ADOC #122 indicated that when a unit was running low on supplies, they would need to request them from the facility charge nurse to restock. ADOC acknowledged that as Personal Support Worker (PSW) #121 approached resident #009 to provide care without appropriate PPE that they failed to participate in the home's infection prevention and control program. (643)

(A1)
2. The MLTC received a complaint regarding infection prevention and control issues within the home.

a) On July 16, 2020, at approx. 1405hrs, a family member wearing full PPE (gown, mask, gloves, goggles) was observed in a hallway leading towards the entrance of the home, outside the resident units. The family member asked Inspector #673 where to take off the PPE and whether it was to be taken off at the entrance. Inspector #673 redirected them back to the resident room they had come from. Notices on the door of the room indicated that the resident the visitor had seen was on isolation. Inspector #672 inquired whether a staff member was nearby to help them. No staff member was observed in the vicinity. PSW #127 was later seen coming down the hall to assist the family member but was observed to not be wearing a mask. In an interview, PSW #127 acknowledged that they should have been wearing a mask in resident care areas and that the visitor should have been given adequate instructions regarding doffing of PPE before exiting the room.

b) On July 16, 2020, Administrator #101 informed the inspection team that a mask and a face shield/goggles are required to be worn by all staff including inspectors when in resident care areas/units, and masks are to be worn at all other times.

Review of a COVID-19 update on daily procedure mask use, dated June 19, 2020, titled Eye Protection Instructions- COVID-19 stated that extended use of eye protection (Goggles or Face Shield) is required for the full duration of the shift.

Inspector #673 made the following observations on July 17, 2020:

- At approximately 1335hrs, housekeeper #128 was observed on a resident unit without goggles or face shield and could not clearly articulate what the home's policy related to PPE was.

-At approximately 1345hrs, PSW #129 was observed sitting at the nursing station on a resident care unit with their mask on their chin and not covering their nose or mouth.

- At approximately 1352 hrs, agency PSW #130 was observed without a face shield/goggles and only a mask. PSW #130 stated they had stopped wearing the face shield one week ago when they forgot to bring it to work. PSW #130 stated they were unaware that the home's policy required them to wear it in resident care areas.

- At 1406 hrs, PSW #131 was observed wearing their goggles on their head in a resident care area and standing near a resident. Upon inquiry of the home's policy related to PPE by Inspector #673, PSW #131 cleaned it and donned the goggles appropriately.

- At approximately 1410 hrs, housekeeper #132 was observed wearing their goggles on the back of their head. Upon inquiry by Inspector #673, they stated that they thought that the home's policy only required them to wear the goggles inside resident rooms.

- At approximately 1412 hrs, Inspector #673 observed resident #025 with respiratory symptoms, touching doorknobs in the hallway and could not identify their name or their room when asked. Inspector #673 guided resident away from entering another resident's room and asked them to wait until a staff member could come to assist. Approx. 3-4 minutes later, PSW #133 guided resident #025 back to their room. Resident #025's room door had a sign indicating that they were in isolation. PSW #133 stated that the resident was in isolation as they were a new admission and that staff had just found out that residents are required to remain in isolation for two weeks, not two days, upon admission if they hadn't been cleared for COVID-19. PSW #133 was observed to with inappropriate PPE while they guided resident #025 back into their room.

-At approximately 1420 hrs, agency PSW #134 was observed to have come out of a resident room. PSW #134 stated that they had just finished providing assistance to a nurse with wound care for a resident. PSW #134's mask was falling off their face and was noted to not have been sealed at the bridge of the nose.

- At 1440 hrs, agency PSW #135 was observed walking out of room the resident's

room with their mask hanging off one ear. When Inspector #673 asked about the mask, they stated that they had been eating a yogurt in the resident's room. PSW #135 proceeded back into the room and continued to eat their yogurt. PSW #135 acknowledged that they should not be eating in the resident's room, and that they should be wearing their mask appropriately.

-At approximately 1520 hrs, two staff members were observed on a resident unit. One staff member had just a mask on and PSW #136, had their goggles on top of their mask. Upon questioning about the home's policy regarding PPE, PSW #136 took them off their mask and put them on their eyes. PSW #136 acknowledged that the home's expectation was for masks and face shields/goggles to be worn at all times in resident care areas.

At the end of the day on July 17, 2020, Inspector #673 informed Administrator #101 of their observations due to the level of risk related to IPAC issues during a pandemic. On July 20, 2020, Inspector #673 was informed by DOC #100 that education had been provided to staff over the course of the last three days. DOC #100 acknowledged the inconsistency in messaging and practice of the home's expectations/policies related to staff wearing PPE in the home.

c) On July 21, 2020, at approximately 1221 hrs, RPN #105 was observed to be assisting one resident, then cleaning the tables of other residents and dumping dining utensils into water and putting them away. RPN #105 was observed to then proceed back to the initial resident and assisted them again without performing hand hygiene. In an interview, RPN #105 acknowledged that hand hygiene should have been performed after cleaning and prior to assisting the resident.

On August 4, 2020, at 1115 hrs, summer student #137 was observed next to resident #026 with some PPE on. Signs on the door of the room indicated that the residents inside were on isolation and staff were required to wear appropriate PPE. Summer student #137 was observed exiting the room and not performing hand hygiene until reminded to do so by the inspector.

On August 10, 2020, at 1400 hrs, housekeeper #138 was observed exiting a resident room after cleaning. Housekeeper #138 was wearing double gloves, the inner glove was ripped, and they performed hand hygiene with hand sanitizer onto the outer gloves. Housekeeper #138 was also observed taking off their PPE with their gown

being removed before gloves (contrary to signs on door of steps on how to remove PPE), and taking off gloves using an incorrect technique. Housekeeper #138 stated that they had received training in PPE donning and doffing and IPAC, and that they wore two gloves as the hand sanitizer made their hands sticky.

On August 11, 2020, at 1624 hrs, Inspector #673 was at the nursing station and observed a staff member ask RPN #139 to help resident #026 make a phone call. Resident #026 was a new admission and was on isolation and was not observed to be wearing any PPE. Inspector #673 informed RPN #139 that resident #026 is supposed to be on isolation to which they responded that they were aware, but the resident would not remain in isolation due to their behaviour. Inspector #673 inquired whether there was an alternative way to help resident #026 make their phone call and suggested using the cordless phone in their room. RPN #139 did not respond, proceeded to help resident #026 make a phone call across from the nursing station where Inspector #673 was seated. While resident #026 was on the phone, they had some respiratory symtpoms, sending droplets all over the table and documents. RPN #139 attempted to wipe down table.

In an interview, Interim Administrator #100 acknowledged that staff were not participating in the implementation of the infection prevention and control program. (673)

3. The following noncompliance for resident #003 issued under O. Reg. 79/10, s. 229 (4) was identified in inspection #2020_714673_0004, which was completed concurrently.

The MLTC received a complaint regarding IPAC issues within the home.

The complainant provided audio recordings to the inspector. In a recording, the complainant is heard showing and explaining to PSW #117 how they wear double gloves when visiting the home. PSW #117 did not respond to correct the complainant's practice.

In an interview, PSW #117 stated that wearing double gloves is not best practice and that if a family member were to wear double gloves, it would be the responsibility of the home's staff to correct and educate the family member in order to protect the residents.

In an interview, Interim Administrator #100 acknowledged that staff were not participating in the implementation of the infection prevention and control program.

The severity of this issue is a level 2 (minimal harm or minimal risk), the scope was a level 3 (widespread), in the home and compliance history was level 3 (previous non-compliance to the same subsection) that included Voluntary Plan of Action (VPC) and Written Notification (WN) issued during Inspection # 2019_780699_0020, dated October 17, 2019, and # 2018_751649_0012, dated August 28, 2018. (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 20, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Ontario

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Ministère des Soins de longue durée

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Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

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

Ordre(s) de l'inspecteur

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RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of October, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by NITAL SHETH (500) - (A1)

Ontario

Ministry of Long-Term Care

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