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
Feb 26, 2021	2021_823653_0001 (A1)	025174-20, 025321-20, 025325-20, 025598-20, 025634-20, 025683-20, 025910-20, 025987-20, 000028-21, 000353-21	Complaint

Licensee/Titulaire de permis

Tendercare Nursing Homes Limited
20 High Park Blvd. Toronto ON M6R 1M7

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

Tendercare Living Centre
1020 McNicoll Avenue Scarborough ON M1W 2J6

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

Amended by ROMELA VILLASPIR (653) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home and the hospital had requested to extend the compliance dates of compliance orders #001, #003, #004, and #005, to March 25, 2021, to ensure all actions are completed.

Issued on this 26th day of February, 2021 (A1)

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

Original report signed by the inspector.

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

Amended by ROMELA VILLASPIR (653) - (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): January 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 2021.

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

Complaint Log #(s):

025321-20 and 025910-20 related to nutrition and hydration concerns;

025325-20 related to feeding assistance and continence care not provided;

025598-20 related to insufficient staffing, training not provided to agency staff, and late medication administration;

025634-20 related to an injury sustained from unknown cause, SDM not notified with changes concerning the resident, food and fluid intake not monitored, and complaint procedures;

025683-20 related to insufficient staffing, feeding assistance not provided, food and fluid intake not monitored, and the SDM not notified with changes concerning the resident;

025987-20 related to Infection Prevention and Control (IPAC) practices, personal support services, continence care, maintenance, staffing, and nutrition and hydration concerns;

000028-21 related to allegation of resident neglect, feeding assistance not provided, IPAC practices, and lack of staff training;

000353-21 related to IPAC practices, personal support services, continence care, sufficient staffing, and nutrition and hydration concerns.

Follow-up Log #025174-20, CO #001 issued on December 17, 2020, within report #2020_838760_0041, related to O. Reg. 79/10, s. 229 (4).

During the course of the inspection, the inspectors toured the home, observed the residents, provision of care, medication administration, in-room meal services, staff to resident interaction, IPAC practices, reviewed clinical health records, staffing schedule, staffing plan, staff training records, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Family Members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Housekeepers, Agency PSWs, Agency RPNs, Social Worker (SW), Program Manager (PM), Registered Dietitian (RD), Dietitian Supervisor (DS), Receptionists, Environmental Services Manager (ESM), Physician, Assistant Director of Care (ADOC), and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Training and Orientation

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

13 WN(s)
7 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to resident #008.

A review of the prescriber’s digiorder form indicated that the physician ordered to start a treatment for seven days, and then to re-assess. A review of the physician's progress note seven days later, indicated the resident was still taking minimal oral intake, and to re-assess the treatment weekly. However, no new order was written on the prescriber’s digiorder form in regards to the treatment. During an observation conducted by Inspector #653 two days following the physician's progress note, the resident had the treatment in place without specific directions. During an interview, the Assistant Director of Care (ADOC) acknowledged that resident #008’s written plan of care did not set out clear directions to staff and others who provided direct care to the resident, as it related to the treatment order.

Sources: Prescriber’s digiorder form, eMAR, progress notes; Inspector #653’s observation; Interview with the ADOC. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the Substitute Decision-Makers (SDMs)

of residents #001, #002, #006, and #007 were provided the opportunity to participate fully in the development and implementation of the residents' plan of care.

The Ministry of Long-Term Care (MLTC) received a complaint regarding a lack of communication from the home to the SDMs of the residents, during the course of the outbreak. A review of resident #001 and #002’s progress notes indicated that both residents had tested positive for the virus during the outbreak, however, the notes did not indicate that their SDMs were informed of their diagnosis, until five days later. Registered Practical Nurse (RPN) #121 indicated that it was the responsibility of the management team to inform the SDMs of the residents who tested positive for the virus. The ADOC confirmed that the home’s usual process would be to immediately inform the SDMs after a resident has tested positive for the virus, and document on the progress notes when the SDMs were informed. The ADOC confirmed that the SDMs of both residents were not immediately informed as required.

Sources: Resident #001 and 002’s progress notes; Interviews with RPN #121, the ADOC and other staff members. [s. 6. (5)]

3. The MLTC received a complaint regarding resident #006’s family not receiving updates regarding the resident. A review of resident #006’s progress notes indicated they tested positive for the virus, and were moved to another Room (RM). Separate interviews with the Social Worker (SW) and Program Manager (PM) indicated that the notification to the SDM regarding an internal move, would usually be documented in the progress notes, and they further acknowledged that the resident’s SDM was not informed of the internal move.

Sources: Progress notes; Interviews with the SW and PM. [s. 6. (5)]

4. The MLTC received a complaint regarding resident #007's family not being informed of their fall and injury. A review of the resident's progress note indicated the resident had a fall at their bedside, and sustained an injury. RPN #146 endorsed to RPN #125 to inform the SDM. An interview with RPN #125 indicated they do not recall being asked by RPN #146 to inform the SDM about the fall and injury. The RPN acknowledged that the SDM was not notified regarding the resident’s fall and injury. An interview with the Director of Care (DOC) indicated that as per the home’s policy, when a resident had fallen, the family must be informed, and further acknowledged that in this case, resident #007's family had

not been informed.

Sources: Progress notes; Interviews with RPN #125 and the DOC. [s. 6. (5)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #006, #009, and #010, as specified in the plan.

A review of resident #006's plan of care indicated they disliked a particular beverage. During an interview, Personal Support Worker (PSW) #102 indicated to the inspector that the resident had poor fluid intake, and only had two sips of the beverage, as the resident found it sour. The PSW stated they were not the primary PSW for the resident, and had no awareness of their dislike for the beverage. An interview with the Dietitian Supervisor (DS) indicated that the staff should not have given the beverage to the resident, and provided other alternatives instead.

Sources: Care plan and kardex; Interviews with PSW #102 and the DS. [s. 6. (7)]

6. A review of resident #006's prescriber's digiorder form indicated that the physician ordered to continue a treatment.

During three separate observations, Inspector #653 noted that the resident did not receive the treatment as ordered. Separate interviews with RPN #109 and RN #135 identified that care was not provided to resident #006 as specified in the plan, as it related to the treatment.

Sources: Prescriber's digiorder form; Inspector #653's observations; Interviews with RPN #109, and RN #135. [s. 6. (7)]

7. A review of resident #009's prescriber's digiorder form indicated that the physician ordered a treatment. During an observation, Inspector #653 noted that the resident did not receive the treatment as ordered.

Sources: Prescriber's digiorder form; Inspector #653's observation. [s. 6. (7)]

8. A review of resident #010's prescriber's digiorder form indicated that the physician ordered to continue a treatment.

During an observation, Inspector #653 noted that the resident did not receive the

treatment as ordered.

During an interview, the ADOC acknowledged the inspector's observations, and that care was not provided to residents #006, #009, and #010 as specified in the plan with regards to their treatment orders. The ADOC further acknowledged the risk for dehydration as the residents were not receiving the treatment as ordered.

Sources: Prescriber's digiorder form; Inspector #653's observation; Interview with the ADOC. [s. 6. (7)]

Additional Required Actions:

CO # - 001 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# 001

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
-there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident;
-the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home was issued a compliance order on December 17, 2020, within report #2020_838760_0041, related to O. Reg. 79/10, s. 229 (4). A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's IPAC program during the on-going respiratory outbreak.

During the course of the inspection, all residents in the home remained isolated in their rooms, and were on droplet and contact precautions.

The following observations were conducted by Inspectors #760 and #653:

-PSW #112 donned their Personal Protective Equipment (PPE) while walking in the hallways. Following the observation, the PSW stated to the inspector that the home's expectation was to don their PPE in front of the resident's room, prior to entry.
-PSW #102 did not fully don their gloves and part of their hand was exposed. The PSW entered the room and fed the resident their snacks.
-PSW #106 was noted going back and forth the two residents in the same room, while providing assistance with breakfast meal. The PSW completed hand hygiene and changed their gloves in-between resident contact, but they did not change their gown. At one point, PSW #106 did not fully don their gloves and part of their hand was exposed.
-RN #108 sanitized both of their hands while holding a plate.
-While donning the gown, Housekeeper (HK) #107 created a hole for their right and left thumb on each sleeve by puncturing the gown with their thumb.
-PSW #113 entered the room to provide feeding assistance to the resident, however, the PSW was not wearing gloves. The PSW kept gloves in the pockets of their scrubs, stated they were clean, and would don those gloves inside the room, prior to feeding the resident. After further clarification, the PSW stated that

the home’s expectations was to don gloves prior to entering a resident’s room.
-PSW #114 entered the room without gown and gloves, and placed the resident’s meal tray right by the television. Following the observation, the PSW stated to the inspector that they were required to don full PPE prior to entering a resident’s room, regardless of what they were going to do inside.
-PSW #101 was noted walking towards the washroom, coming from bed #2, and was not wearing gloves. The PSW washed their hands inside the washroom, and returned to bed #2, wherein they donned new gloves.
-PSW #101 was not wearing gloves and handled the resident’s sandwich with bare hands, and fed the resident. The PSW also touched the call bell and bed remote without gloves. The same PSW was noted to re-enter the room without wearing full PPE, to take the finished meal tray.
-Inspector #760 also observed the lack of leadership on the floors, and some staff were not clear on the appropriate IPAC practices.

During separate interviews, the DOC and ADOC acknowledged the above mentioned observations by the inspectors, and further acknowledged that the staff did not participate in the implementation of the home's IPAC program.

Sources: Observations; Interviews with staff, ADOC, and DOC. [s. 229. (4)]

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. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the hydration program included the implementation of interventions to mitigate and manage the identified risks related to hydration.

A review of the home’s policy, titled "Food and Fluid Intake Monitoring", revealed that if a resident did not meet their individualized fluid target for three consecutive days, the nurse must complete a Nursing Hydration Assessment. The policy also indicated that a referral to the Registered Dietitian (RD) has to be completed if the resident consumed 50 per cent or less from all meals for three or more days, or refuses supplements/ special labelled items or nutritional interventions for three consecutive days, or has demonstrated a significant change in their normal food intake pattern.

A review of progress notes indicated resident #006 tested positive for the virus during the outbreak, and a review of their weight summary revealed they lost weight between December 2020, and January 2021.

A review of the resident's care plan indicated they were to maintain a specific daily fluid intake amount. The RD indicated that the resident was at nutritional risk back in December 2020, due to their diagnosis, and having had poor food, and fluid intake.

A review of progress notes and look back report for food and fluid intake for a period of 11 days in December 2020, indicated that resident #006 did not meet their daily fluid goal, and only consumed fifty per cent or less from all meals for more than three days.

A review of Point Click Care (PCC) assessments and progress notes did not identify that a Nursing Hydration assessment was completed for the poor fluid intake, and there was no dietary referral sent when the resident had poor food intake.

Sources: Food and Fluid Intake Monitoring policy; PCC assessments, progress notes, food and fluid look back report, care plan; Interviews with the DS and RD. [s. 68. (2) (c)]

2. The MLTC received a complaint which indicated that resident #007 complained of hunger in their last few days at the home, prior to hospital admission.

A review of progress notes indicated the resident tested positive for the virus during the outbreak. A review of their care plan indicated they were to maintain a specific daily fluid intake amount. The care plan also indicated the resident had decreased oral intake and hydration due to their diagnosis. An interview with the RD indicated that the resident was at nutritional risk back in December 2020, and experienced a decline due to their diagnosis.

A review of progress notes and look back report for food and fluid intake four days prior to the resident's hospital admission, indicated that resident #007 did not meet their daily fluid goal, and only consumed fifty per cent or less from all meals for more than three days. The resident was noted to be lethargic, weak, and had poor appetite.

A review of PCC assessments and progress notes did not identify that a Nursing Hydration assessment was completed for the poor fluid intake, and there was no dietary referral sent when the resident had poor food intake.

Separate interviews with the DS and RD indicated that due to having insufficient staffing and mostly agency staff working back in December 2020, there were gaps with documentations of food and fluid intake, as well as sending of dietary referrals. The RD further indicated that the risk associated to not monitoring and evaluating a resident's food and fluid intake would be possible weight loss, dehydration, delay in assessment and interventions, and the resident not being well nourished.

Sources: Food and Fluid Intake Monitoring policy; PCC progress notes, care plan, food and fluid look back report, assessments; Interviews with the DS and RD. [s. 68. (2) (c)]

3. The MLTC received complaints related to the lack of nutritional care provided to residents #001 and #002.

As per resident #001's care plan, they required a specific daily fluid intake amount. A review of the Point of Care (POC) records indicated the resident was not meeting their required fluid intake in the last few weeks of December 2020, continuing towards the beginning of January 2021. During this period, the resident had a change in their food intake, and there was also missing documentation related to their intake. There was no hydration assessment completed when they had a change in their fluid intake. Separate interviews with Agency PSW #145 and PSW #120 indicated that the resident had a decline in their food and fluid intake following the passing of their spouse in January 2021.

There was actual risk to resident #001 as their food and fluid intake were not monitored, and there was no hydration assessment completed when they had a change in their fluid intake. As a result, interventions that could have improved the resident's food and fluid intake, may not have been provided.

Sources: Food and Fluid Intake Monitoring policy, resident #001's care plan, food and fluid intake on POC, assessments on PCC; Interviews with Agency PSW #145, PSW #120,and the RD. [s. 68. (2) (c)]

4. A review of the records indicated that resident #002 had a change in their food and fluid intake around the middle, to the end of December 2020. The documentation was incomplete around this period as well. Their care plan indicated that they required a specific daily fluid intake amount. A review of the POC documentation indicated that the resident did not meet their daily required

fluid intake for a three week period, and a hydration assessment was not completed related to the change in the resident’s fluid intake. An interview with PSW #120 indicated at one point, the resident was refusing to eat anything. The RD confirmed that the resident should have had a hydration assessment completed, however, it was not completed. The ADOC further indicated that there was no proper monitoring of the resident’s food and fluid intake on POC, as per the home’s policy, when they had a change in their food and fluid intake.

There was actual risk to resident #002 as their food and fluid intake were not monitored, and there was no hydration assessment completed when they had a change in their fluid intake. As a result, interventions that could have improved the resident’s food and fluid intake, may not have been provided.

Sources: Food and Fluid Intake Monitoring policy, resident #002’s care plan, food and fluid intake on POC, assessments on PCC; interviews with PSW #120, RD, ADOC, and other staff. [s. 68. (2) (c)]

5. The MLTC received complaints related to the care provided to resident #003 prior to their passing. The complaints included concerns related to their food and fluid intake.

A review of the resident's look back report for food and fluid intake, indicated that there was a change in their intake after they had tested positive for the virus during the outbreak. The documentation was incomplete on certain meal and snack periods. The resident’s care plan indicated they were to maintain a specific daily fluid intake amount. The fluid intake report indicated that they were not meeting their fluid target goals, and a hydration assessment was not completed as required by the home's policy. Agency PSW #141 confirmed that the resident had a decrease in their food and fluid intake a week before they were sent to the hospital. The RD reviewed the resident’s fluid intake and confirmed that a hydration assessment was not done but should have been completed. The DOC stated that the staff should have documented the resident’s daily food and fluid intake.

There was actual risk of harm to the resident due to the lack of monitoring of their food and fluid intake, which resulted in the lack of proper assessment and implementation of interventions related to their nutritional status.

Sources: Food and Fluid Intake Monitoring policy, resident #003’s food and fluid

intake on POC, care plan, assessments on PCC; Interviews with Agency PSW #141, RD, DOC, and other staff. [s. 68. (2) (c)]

Additional Required Actions:

CO # - 003 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# 003

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian who was a member of the staff of the home completed a nutritional assessment for residents #001, #002, #003, and #006, when there was a significant change in their health condition, and assessed the resident's nutritional status, including height, weight and any risks related to nutrition care, and hydration status, and any risks related to hydration.

The MLTC received a complaint regarding resident #006's poor nutrition and hydration status, after being diagnosed positive for the virus during the outbreak. A review of resident #006’s weight summary revealed they lost weight between December 2020, and January 2021. A review of progress notes and look back report for food and fluid intake for a period of 11 days in December 2020, indicated that resident #006 did not meet their daily fluid goal, and only consumed fifty per cent or less from all meals for more than three days. Six days after the resident was diagnosed positive for the virus, the RD recommended to provide a dietary supplement as per the Nutrition and Hydration Pathway protocol, due to decreased intake and increased hydration needs. A day after the RD"s recommendation, the resident was also started on a treatment as per the physician’s order, due to signs of dehydration.

An interview with the RD indicated that a nutritional assessment of a resident would include the review of a resident’s weight, food and fluid intake, current orders, recent bloodwork, and they would also speak to the resident if possible, to find out their preferences, and speak to the staff if they had noticed any changes in the resident. Following the assessment, the RD would then document their recommendations. The RD acknowledged that when they implemented the nutrition and hydration protocol for resident #006, it was mainly due to the fact that the resident had tested positive for the virus. The RD acknowledged that a nutritional assessment as described above, was not completed for resident #006 when they had a significant change in condition after they had tested positive for the virus, and when they were not meeting their nutrition and hydration needs due to poor food and fluid intake. There was actual risk of harm to resident #006 resulting from the lack of nutritional assessment by the RD when the resident had a significant change in their health condition, as evidenced by the lack of further dietary interventions to address their poor food and fluid intake.

Sources: Progress notes, food and fluid look back report, care plan; Interview with the RD. [s. 26. (4) (a),s. 26. (4) (b)]

2. The MLTC received complaints related to the lack of nutritional care provided to the residents #001, #002, and #003.

As per the home’s food and fluid intake monitoring policy, a referral was to be made to the RD or designate if a resident consumed 50 per cent or less from all three or more days or had demonstrated significant change in their normal food intake pattern. In addition, the policy stated that the RD would be referred to if

there were signs or symptoms of dehydration present.

A review of resident #001's look back report for food and fluid intake, indicated they had a change in their intake in the last few weeks of December 2020, continuing towards the beginning of January 2021. An assessment of the resident's change in their nutritional status was not found in their chart. Separate interviews with Agency PSW #145 and PSW #120 indicated that the resident had a decline in their food and fluid intake following the passing of their spouse in January 2021. The RD stated they were not informed about the change in the resident's food and fluid intake, and as per the review of the resident's documentation and the home's policy, they should have been referred to the RD. There was actual risk of harm to the resident as a nutritional assessment was not completed when they had a change in their food and fluid intake, resulting in lack of further interventions implemented for the resident.

Sources: Resident #001's assessments, food and fluid intake monitoring from POC; Interviews with Agency PSW #145, PSW #120, RD, and other staff. [s. 26. (4) (a),s. 26. (4) (b)]

3. A review of the records indicated that resident #002 had a change in their food and fluid intake around the middle, to the end of December 2020. An RD referral or nutritional assessment of the resident were not completed. An interview with PSW #118 confirmed that the resident was refusing their meals more often, after they had tested positive for the virus during the outbreak. RPN #136 indicated that due to the home's outbreak and lack of family visitation, they had a decrease in their food intake. The RPN stated they did not inform the RD to assess the resident. The RD stated the resident started to have a decline in their intake around third week of December, as they were refusing to eat. The RD stated they were not informed of the resident's change in intake and they did not conduct a nutritional assessment on the resident. The RD further indicated that based on the home's policy, the nursing staff should have referred the resident for an assessment by the RD. There was actual risk of harm to the resident as a nutritional assessment was not completed when they had a change in their food and fluid intake due to their diagnosis, resulting in lack of further interventions implemented for the resident.

Sources: Resident #002's assessments, food and fluid intake monitoring from POC; Interviews with RPN #126, PSW #118, RD, and other staff. [s. 26. (4) (a),s. 26. (4) (b)]

4. A review of resident #003's look back report for food and fluid intake, indicated that there was a change in their intake after they had tested positive for the virus during the outbreak. The progress notes indicated they were assessed by the physician and poor oral intake was noted. A nutritional assessment by the RD was not found on the resident's chart. RN #124 stated that the resident was not eating nor drinking well, and they indicated that an RD assessment or referral was not completed. The RD reviewed the resident's look back report for food and fluid intake, and stated that they should have been involved in addressing the resident's food and fluid intake. The RD confirmed they did not do a nutritional assessment on the resident, when they had a change in their food and fluid intake. There was actual risk of harm to the resident as a nutritional assessment was not completed when they were confirmed to have had a change in their food and fluid intake, resulting in the lack of specific interventions implemented for their nutritional status at that time.

Sources: Resident #003's food and fluid intake on POC, progress notes; Interviews with RN #124, RD, and other staff. [s. 26. (4) (a),s. 26. (4) (b)]

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who required assistance with eating or drinking, was served a meal until someone was available to provide the assistance required by the resident.

The MLTC received complaints related to care concerns and staffing crisis that transpired during the home's respiratory outbreak. The DOC indicated that the home's staffing had significantly reduced during the outbreak, which impacted resident care.

RN #119 indicated that around the end of December 2020, due to the home's shortage of front line staff, they were unable to provide assistance to all residents with their breakfast meals, and by the time they reached the remaining residents to assist them with their breakfast, lunch meal trays were beginning to be served. PSW #118 stated that during one of their shifts, due to insufficient staffing, they were unable to let the residents eat and finish their meals at their own pace, as they had to go and assist the next resident. RPN #115 also stated there were occasions wherein they did not have sufficient staff to help with feeding, so staff were still providing feeding assistance to residents at 2000hrs, for the supper meal trays that were served at 1700hrs. On one occasion, RN #124 stated they walked past resident #011's room close to lunch time, and noted the resident had not received assistance with their breakfast meal. The DOC also stated they observed similar concerns when they were on the floor assisting residents with care, during the home's respiratory outbreak. The DOC also mentioned on one occasion, they went in resident #005's room to provide assistance, and the resident refused to eat their meal as it was already cold. There was actual risk of harm to the residents as meals were being served to them at a time when staff were not available to provide the required assistance, and the delay in assistance compromised the integrity of the food, becoming unpalatable for residents, which may have also potentially lead to a decrease in their food and fluid intake.

Sources: Resident #011's care plan, POC documentation, progress notes; Interviews with the DOC, RNs #119 & #124, PSW #118, RPN #115 and other staff. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 005 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# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Medication Management policy was complied with by the registered staff.

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

A review of the home's policy titled "Medication Management" indicated under procedures, that the nurse will immediately document all medications administered, refused or omitted, after administration on the MAR/ eMAR and TAR/ eTAR using the proper codes by the administering nurse.

A review of the Medication Administration Audit Reports revealed that RN#124 and RPN #134 did not immediately document all medications administered following administration, for residents #016, #017, #018, and #019,

Separate interviews with RN #124 and RPN #134 indicated that due to the short staffing back in December 2020, they had to help out with feeding and providing continence care to the residents. The registered staff stated there were times they administered medications within the scheduled times, but signed off on the eMAR at a later time when they had the chance to sit at the desk and complete their documentation.

During an interview, the ADOC reviewed the above mentioned Medication Administration Audit Reports and acknowledged that the registered staff did not comply with the home's policy when they did not immediately sign off on the eMAR following medication administration. The ADOC further indicated there was potential for affecting continuity of care and may also possibly result in medication error incidents. The ADOC stated they encouraged the staff to write a progress note to indicate reason for late documentation.

Sources: Medication Administration Audit Reports; Interviews with RN#124, RPN #134, and the ADOC. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents, was complied with.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" indicated that at minimum, any individual who witnesses or suspect abuse or neglect of a resident must notify management immediately. Staff must complete an internal incident report and notify their supervisor (or during after-hours the Nurse on site). The Nurse would then call the Manager on-call or General Manager/ designate immediately upon suspecting or becoming aware of abuse or neglect of a resident.

The MLTC received a complaint regarding a staff member reporting allegations of neglect to an external provider, instead of their supervisor at the home. During an interview, the DOC indicated that the staff's supervisor was not aware of any of allegations of resident neglect. The DOC further acknowledged that the staff did not comply with the home's policy on prevention of abuse, as the staff did not immediately notify the home's management regarding their allegations.

Sources: Home's policy on Zero Tolerance of Resident Abuse and Neglect: Response and Reporting; Interviews with the staff and DOC. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

RN #124 stated that the grooming of the residents were not well done during the respiratory outbreak, which included an identified care not provided to resident #013. A review of their care plan indicated they required staff assistance for personal care, and there was no documentation to support that personal care was provided to the resident for a period of two weeks.

Sources: Resident #013's care plan, chart; Interviews with RN #124 and other staff. [s. 32.]

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 each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

**s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that any resident who was dependent on staff for repositioning, was repositioned every two hours or more frequently as required depending upon their condition.

Agency PSW #145 stated that due to short staffing during the respiratory outbreak, the focus was on feeding the residents, and they did not have the time to reposition the totally dependent residents who required to be repositioned. The ADOC indicated that they noticed a number of residents developed new alteration in skin integrity due to lack of turning and repositioning. There was actual risk of harm to the residents as the lack of repositioning resulted in new alteration in skin integrity.

Sources: Interviews with Agency PSW #145, ADOC, and other staff. [s. 50. (2) (d)]

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 any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who required continence care products, had sufficient changes to remain clean, dry and comfortable

PSW #118 stated that during one of their shifts in December 2020, they were only able to do one brief change for each resident they were assigned to, due to the lack of staff. Agency PSW #145 stated they worked shifts wherein they could not provide continence care to all assigned residents because of staff shortage on the floor. RN #124 stated on one occasion, resident #012 was not provided continence care for an entire day because of their resistance towards staff, and there were not enough staff to support the resident's responsive behaviours. The DOC observed similar concerns when they were on the floor, related to the lack of continence care provided to residents, which included resident #002, who the DOC believed should have had more frequent continence care changes. There was actual risk of harm to residents, as the lack of continence care may lead to further alteration in skin integrity and urinary tract infections.

Sources: Resident #012's chart; Interviews with PSW #118, Agency PSW #145, RN #124, the DOC and other staff. [s. 51. (2) (g)]

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 residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #11: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received training in the following areas before performing their responsibilities:
1. The Residents' Bill of Rights
2. The home's mission statement
3. The home's policy to promote zero tolerance of abuse and neglect of residents
4. The duty to make mandatory reports under section 24
5. The whistle-blower protections under section 26
6. The home's policy to minimize the restraining of residents
7. Fire prevention and safety
8. Emergency and evacuation procedures
9. Infection prevention and control
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities
11. Any other areas provided for in the regulations.

The MLTC received a complaint regarding a staff member reporting allegations of neglect to an external provider, instead of their supervisor at the home. During an interview, the DOC indicated that the staff's supervisor was not aware of any of allegations of resident neglect. During an initial interview, the staff member indicated they did not receive training on reporting abuse and neglect. During an interview, the ADOC indicated back in December 2020, the home was in staffing crisis due to the respiratory outbreak, and mandatory education of staff did not take place. The ADOC further indicated that the priority at that time was to staff the home.

Sources: Interviews with staff and the ADOC. [s. 76. (2)]

2. During an interview, the DOC confirmed that the home used many agency staff during the course of the respiratory outbreak. However, the home was unable to provide training records of the agency staff members. Agency PSW #145 indicated they did not review any policies from the home, prior to beginning their first shift at the home. The ADOC indicated they understood that every staff of the home were to receive mandatory training on the policies of the home prior to commencing their shift on the unit, however, the ADOC was unable to provide any evidence that the home trained the staff prior to them commencing their first shift during the outbreak.

Sources: Home's staffing schedule; Interviews with Agency PSW #145, the DOC,

ADOC, and other staff. [s. 76. (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 no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to immediately forward the written complaint received concerning the care of resident #007, to the Director.

The MLTC received a complaint regarding resident #007's SDM not being informed of the resident's fall and injury. A review of the SDMs e-mail correspondence sent to the receptionist and the DOC, indicated that the resident was at the hospital, and the SDM had learned that the resident sustained an injury at the home, prior to hospital admission. The SDM raised concerns regarding the incident that caused the injury, and questioned why the family was not notified. During an interview, the DOC indicated around that time period, they were the only manager left working at the home, and there were a lot of phone calls they did not return due to their very busy schedule. The DOC could not remember seeing the e-mail correspondence, and acknowledged that it was not forwarded to the MLTC.

Sources: E-mail correspondence from resident #007’s SDM; Interview with the DOC. [s. 22. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written complaint made to the licensee concerning the care of resident #007, had been investigated, resolved where possible, and that a response was provided within ten business days of receipt of the complaint.

The DOC stated that when they receive written complaints, they would normally call the family, find out what their concerns were, address them, and respond back in writing. The DOC could not remember seeing the e-mail correspondence from resident #007's SDM, and acknowledged that the written complaint was not investigated and resolved, and that a response was not provided to the SDM within ten business days of receipt of the complaint.

Sources: E-mail correspondence from resident #007's SDM; Interview with the DOC. [s. 101. (1) 1.]

Issued on this 26th day of February, 2021 (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

Ordre(s) de l'inspecteur

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

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by ROMELA VILLASPIR (653) - (A1)
Inspection No. / No de l'inspection :	2021_823653_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	025174-20, 025321-20, 025325-20, 025598-20, 025634-20, 025683-20, 025910-20, 025987-20, 000028-21, 000353-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 26, 2021(A1)
Licensee / Titulaire de permis :	Tendercare Nursing Homes Limited 20 High Park Blvd., Toronto, ON, M6R-1M7
LTC Home / Foyer de SLD :	Tendercare Living Centre 1020 McNicoll Avenue, Scarborough, ON, M1W-2J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Francis Martis

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 Tendercare Nursing Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA, 2007.

Specifically, the licensee shall create and implement a process to ensure that residents prescribed with a treatment, receive the treatment as ordered.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #006, #009, and #010, as specified in the plan.

A review of resident #006's prescriber's digiorder form indicated that the physician ordered to continue a treatment.

During three separate observations, Inspector #653 noted that the resident did not receive the treatment as ordered. Separate interviews with Registered Practical Nurse (RPN) #109 and Registered Nurse (RN) #135 identified that care was not provided to resident #006 as specified in the plan, as it related to the treatment.

Sources: Prescriber's digiorder form; Inspector #653's observations; Interviews with RPN #109, and RN #135.
(653)

2. A review of resident #006's plan of care indicated they disliked a particular beverage. During an interview, Personal Support Worker (PSW) #102 indicated to the inspector that the resident had poor fluid intake, and only had two sips of the beverage, as the resident found it sour. The PSW stated they were not the primary PSW for the resident, and had no awareness of their dislike for the beverage. An interview with the Dietitian Supervisor (DS) indicated that the staff should not have given the beverage to the resident, and provided other alternatives instead.

Sources: Care plan and kardex; Interviews with PSW #102 and the DS. (653)

3. A review of resident #009's prescriber's digiorder form indicated that the physician ordered a treatment. During an observation, Inspector #653 noted that the resident did not receive the treatment as ordered.

Sources: Prescriber's digiorder form; Inspector #653's observation. (653)

4. A review of resident #010's prescriber's digiorder form indicated that the physician ordered to continue a treatment.

During an observation, Inspector #653 noted that the resident did not receive the treatment as ordered.

During an interview, the Assistant Director of Care (ADOC) acknowledged the inspector's observations, and that care was not provided to residents #006, #009, and #010 as specified in the plan with regards to their treatment orders. The ADOC further acknowledged the risk for dehydration as the residents were not receiving the treatment as ordered.

Sources: Prescriber's digiorder form; Inspector #653's observation; Interview with the ADOC.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because they already had poor food and fluid intake, and not receiving the treatment as ordered, put them at further risk for dehydration.

Scope: The scope of this non-compliance was widespread because three of the three residents reviewed did not receive their treatments as ordered.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with s. 6 (7) of the LTCHA, and two WNs, a VPC, and a CO, were issued to the home. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 25, 2021(A1)

Order # / No d'ordre: 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2020_838760_0041, CO #001;

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.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with the appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with the appropriate IPAC measures.

Grounds / Motifs :

1. Compliance Order (CO) #001 related to O. Reg. 79/10, s. 229 (4) from Inspection 2020_838760_0041 issued on December 17, 2020, with a compliance due date of December 24, 2020, is being re-issued as follows:

The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's IPAC program during the on-going respiratory outbreak.

During the course of the inspection, all residents in the home remained isolated in

their rooms, and were on droplet and contact precautions.

The following observations were conducted by Inspectors #760 and #653:

-PSW #112 donned their Personal Protective Equipment (PPE) while walking in the hallways. Following the observation, the PSW stated to the inspector that the home's expectation was to don their PPE in front of the resident's room, prior to entry.
-PSW #102 did not fully don their gloves and part of their hand was exposed. The PSW entered the room and fed the resident their snacks.
-PSW #106 was noted going back and forth the two residents in the same room, while providing assistance with breakfast meal. The PSW completed hand hygiene and changed their gloves in-between resident contact, but they did not change their gown. At one point, PSW #106 did not fully don their gloves and part of their hand was exposed.
-RN #108 sanitized both of their hands while holding a plate.
-While donning the gown, Housekeeper (HK) #107 created a hole for their right and left thumb on each sleeve by puncturing the gown with their thumb.
-PSW #113 entered the room to provide feeding assistance to the resident, however, the PSW was not wearing gloves. The PSW kept gloves in the pockets of their scrubs, stated they were clean, and would don those gloves inside the room, prior to feeding the resident. After further clarification, the PSW stated that the home's expectations was to don gloves prior to entering a resident's room.
-PSW #114 entered the room without gown and gloves, and placed the resident's meal tray right by the television. Following the observation, the PSW stated to the inspector that they were required to don full PPE prior to entering a resident's room, regardless of what they were going to do inside.
-PSW #101 was noted walking towards the washroom, coming from bed #2, and was not wearing gloves. The PSW washed their hands inside the washroom, and returned to bed #2, wherein they donned new gloves.
-PSW #101 was not wearing gloves and handled the resident's sandwich with bare hands, and fed the resident. The PSW also touched the call bell and bed remote without gloves. The same PSW was noted to re-enter the room without wearing full PPE, to take the finished meal tray.
-Inspector #760 also observed the lack of leadership on the floors, and some staff were not clear on the appropriate IPAC practices.

During separate interviews, the Director of Care (DOC) and ADOC acknowledged the

above mentioned observations by the inspectors, and further acknowledged that the staff did not participate in the implementation of the home's IPAC program.

Sources: Observations; Interviews with staff, ADOC, and DOC.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because the home was on a respiratory outbreak, and there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread because the occurrence were on the two floors of the LTCH.

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in a compliance order (CO) being re-issued. CO #001 was issued on December 17, 2020, (Inspection 2020_838760_0041) with a compliance due date of December 24, 2020. In the past 36 months, a CO was issued to a different section of the legislation, which had been complied. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2021

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. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with s. 68 (2) of the O. Reg. 79/10.

Specifically, the licensee must:
1. Ensure that all registered staff are trained on the home's "Food and Fluid Intake Monitoring" policy so that the Nursing Hydration Assessment form is completed as required, and actions are taken with respect to resident requirements.

2. Educate all PSWs on food and fluid intake monitoring and documentation requirements.

3. Perform weekly audits until the compliance due date, on residents who have been identified at high risk for nutrition and hydration, to ensure that their food and fluid intake are monitored and evaluated. A copy of this audit will be kept as a record.

Grounds / Motifs :

1. The licensee has failed to ensure that the hydration program included the implementation of interventions to mitigate and manage the identified risks related to hydration.

A review of the home's policy, titled "Food and Fluid Intake Monitoring", revealed that if a resident did not meet their individualized fluid target for three consecutive days, the nurse must complete a Nursing Hydration Assessment. The policy also indicated that a referral to the Registered Dietitian (RD) has to be completed if the resident consumed 50 per cent or less from all meals for three or more days, or refuses supplements/ special labelled items or nutritional interventions for three consecutive days, or has demonstrated a significant change in their normal food intake pattern.

A review of progress notes indicated resident #006 tested positive for the virus during the outbreak, and a review of their weight summary revealed they lost weight between December 2020, and January 2021.

A review of the resident's care plan indicated they were to maintain a specific daily fluid intake amount. The RD indicated that the resident was at nutritional risk back in December 2020, due to their diagnosis, and having had poor food, and fluid intake.

A review of progress notes and look back report for food and fluid intake for a period of 11 days in December 2020, indicated that resident #006 did not meet their daily fluid goal, and only consumed fifty per cent or less from all meals for more than three days.

A review of Point Click Care (PCC) assessments and progress notes did not identify that a Nursing Hydration assessment was completed for the poor fluid intake, and there was no dietary referral sent when the resident had poor food intake.

Sources: Food and Fluid Intake Monitoring policy; PCC assessments, progress notes, food and fluid look back report, care plan; Interviews with the DS and RD. (653)

2. The MLTC received a complaint which indicated that resident #007 complained of hunger in their last few days at the home, prior to hospital admission.

A review of progress notes indicated the resident tested positive for the virus during the outbreak. A review of their care plan indicated they were to maintain a specific daily fluid intake amount. The care plan also indicated the resident had decreased oral intake and hydration due to their diagnosis. An interview with the RD indicated that the resident was at nutritional risk back in December 2020, and experienced a decline due to their diagnosis.

A review of progress notes and look back report for food and fluid intake four days prior to the resident's hospital admission, indicated that resident #007 did not meet their daily fluid goal, and only consumed fifty per cent or less from all meals for more than three days. The resident was noted to be lethargic, weak, and had poor appetite.

A review of PCC assessments and progress notes did not identify that a Nursing Hydration assessment was completed for the poor fluid intake, and there was no dietary referral sent when the resident had poor food intake.

Separate interviews with the DS and RD indicated that due to having insufficient staffing and mostly agency staff working back in December 2020, there were gaps with documentations of food and fluid intake, as well as sending of dietary referrals. The RD further indicated that the risk associated to not monitoring and evaluating a resident's food and fluid intake would be possible weight loss, dehydration, delay in assessment and interventions, and the resident not being well nourished.

Sources: Food and Fluid Intake Monitoring policy; PCC progress notes, care plan, food and fluid look back report, assessments; Interviews with the DS and RD. (653)

3. The MLTC received complaints related to the lack of nutritional care provided to residents #001 and #002.

As per resident #001's care plan, they required a specific daily fluid intake amount. A review of the Point of Care (POC) records indicated the resident was not meeting their required fluid intake in the last few weeks of December 2020, continuing towards the beginning of January 2021. During this period, the resident had a change in their food intake, and there was also missing documentation related to their intake. There was no hydration assessment completed when they had a change in their fluid intake. Separate interviews with Agency PSW #145 and PSW #120 indicated that the resident had a decline in their food and fluid intake following the passing of their spouse in January 2021.

There was actual risk to resident #001 as their food and fluid intake were not monitored, and there was no hydration assessment completed when they had a change in their fluid intake. As a result, interventions that could have improved the resident's food and fluid intake, may not have been provided.

Sources: Food and Fluid Intake Monitoring policy, resident #001's care plan, food and fluid intake on POC, assessments on PCC; Interviews with Agency PSW #145, PSW #120,and the RD. (760)

4. A review of the records indicated that resident #002 had a change in their food and fluid intake around the middle, to the end of December 2020. The documentation was incomplete around this period as well. Their care plan indicated that they required a specific daily fluid intake amount. A review of the POC documentation indicated that the resident did not meet their daily required fluid intake for a three week period, and a hydration assessment was not completed related to the change in the resident's fluid intake. An interview with PSW #120 indicated at one point, the resident was refusing to eat anything. The RD confirmed that the resident should have had a hydration assessment completed, however, it was not completed. The ADOC further indicated that there was no proper monitoring of the resident's food and fluid intake on POC, as per the home's policy, when they had a change in their food and fluid intake.

There was actual risk to resident #002 as their food and fluid intake were not monitored, and there was no hydration assessment completed when they had a change in their fluid intake. As a result, interventions that could have improved the resident's food and fluid intake, may not have been provided.

Sources: Food and Fluid Intake Monitoring policy, resident #002's care plan, food and fluid intake on POC, assessments on PCC; interviews with PSW #120, RD, ADOC, and other staff. (760)

5. The MLTC received complaints related to the care provided to resident #003 prior to their passing. The complaints included concerns related to their food and fluid intake.

A review of the resident's look back report for food and fluid intake, indicated that there was a change in their intake after they had tested positive for the virus during the outbreak. The documentation was incomplete on certain meal and snack periods. The resident's care plan indicated they were to maintain a specific daily fluid intake amount. The fluid intake report indicated that they were not meeting their fluid target goals, and a hydration assessment was not completed as required by the home's policy. Agency PSW #141 confirmed that the resident had a decrease in their food and fluid intake a week before they were sent to the hospital. The RD reviewed the resident's fluid intake and confirmed that a hydration assessment was not done but should have been completed. The DOC stated that the staff should have documented the resident's daily food and fluid intake.

There was actual risk of harm to the resident due to the lack of monitoring of their food and fluid intake, which resulted in the lack of proper assessment and implementation of interventions related to their nutritional status.

Sources: Food and Fluid Intake Monitoring policy, resident #003's food and fluid intake on POC, care plan, assessments on PCC; Interviews with Agency PSW #141, RD, DOC, and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents at high nutritional risk, because the hydration program did not include the implementation of interventions to mitigate and manage the residents' identified risks related to hydration.

Scope: The scope of this non-compliance was widespread because the implementation of interventions to mitigate and manage the identified risks related to hydration, was not completed for five of the five residents reviewed during the inspection.

Compliance History: In the last 36 months, multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation. (760)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 25, 2021(A1)

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. 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 the O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that a registered dietitian completes a nutritional assessment whenever a resident has a significant change in their health condition.

2. Perform weekly audits until the compliance due date, to ensure a nutritional assessment is completed by the registered dietitian on residents who have been identified to have had a significant change in their condition. A copy of this audit will be kept as a record.

Grounds / Motifs :

1. The licensee has failed to ensure that the registered dietitian who was a member of the staff of the home completed a nutritional assessment for residents #001, #002, #003, and #006, when there was a significant change in their health condition, and assessed the resident's nutritional status, including height, weight and any risks related to nutrition care, and hydration status, and any risks related to hydration.

The MLTC received a complaint regarding resident #006's poor nutrition and hydration status, after being diagnosed positive for the virus during the outbreak. A review of resident #006's weight summary revealed they lost weight between December 2020, and January 2021. A review of progress notes and look back report for food and fluid intake for a period of 11 days in December 2020, indicated that resident #006 did not meet their daily fluid goal, and only consumed fifty per cent or less from all meals for more than three days. Six days after the resident was diagnosed positive for the virus, the RD recommended to provide a dietary supplement as per the Nutrition and Hydration Pathway protocol, due to decreased intake and increased hydration needs. A day after the RD"s recommendation, the resident was also started on a treatment as per the physician's order, due to signs of dehydration.

An interview with the RD indicated that a nutritional assessment of a resident would include the review of a resident's weight, food and fluid intake, current orders, recent bloodwork, and they would also speak to the resident if possible, to find out their preferences, and speak to the staff if they had noticed any changes in the resident. Following the assessment, the RD would then document their recommendations. The RD acknowledged that when they implemented the nutrition and hydration protocol for resident #006, it was mainly due to the fact that the resident had tested positive for the virus. The RD acknowledged that a nutritional assessment as described above, was not completed for resident #006 when they had a significant change in condition after they had tested positive for the virus, and when they were not meeting their nutrition and hydration needs due to poor food and fluid intake. There was actual risk of harm to resident #006 resulting from the lack of nutritional assessment by the RD when the resident had a significant change in their health condition, as evidenced by the lack of further dietary interventions to address their poor food and fluid intake.

Sources: Progress notes, food and fluid look back report, care plan; Interview with the RD. (653)

2. The MLTC received complaints related to the lack of nutritional care provided to the residents #001, #002, and #003.

As per the home's food and fluid intake monitoring policy, a referral was to be made to the RD or designate if a resident consumed 50 per cent or less from all three or more days or had demonstrated significant change in their normal food intake pattern. In addition, the policy stated that the RD would be referred to if there were signs or symptoms of dehydration present.

A review of resident #001's look back report for food and fluid intake, indicated they had a change in their intake in the last few weeks of December 2020, continuing towards the beginning of January 2021. An assessment of the resident's change in their nutritional status was not found in their chart. Separate interviews with Agency PSW #145 and PSW #120 indicated that the resident had a decline in their food and fluid intake following the passing of their spouse in January 2021. The RD stated they were not informed about the change in the resident's food and fluid intake, and as per the review of the resident's documentation and the home's policy, they should have been referred to the RD. There was actual risk of harm to the resident as a nutritional assessment was not completed when they had a change in their food and fluid intake, resulting in lack of further interventions implemented for the resident.

Sources: Resident #001's assessments, food and fluid intake monitoring from POC; Interviews with Agency PSW #145, PSW #120, RD, and other staff (760)

3. A review of the records indicated that resident #002 had a change in their food and fluid intake around the middle, to the end of December 2020. An RD referral or nutritional assessment of the resident were not completed. An interview with PSW #118 confirmed that the resident was refusing their meals more often, after they had tested positive for the virus during the outbreak. RPN #136 indicated that due to the home's outbreak and lack of family visitation, they had a decrease in their food intake. The RPN stated they did not inform the RD to assess the resident. The RD stated the resident started to have a decline in their intake around third week of December, as they were refusing to eat. The RD stated they were not informed of the resident's change in intake and they did not conduct a nutritional assessment on the resident. The RD further indicated that based on the home's policy, the nursing staff should have referred the resident for an assessment by the RD. There was actual risk of harm to the resident as a nutritional assessment was not completed when they had a change in their food and fluid intake due to their diagnosis, resulting in lack of further interventions implemented for the resident.

Sources: Resident #002's assessments, food and fluid intake monitoring from POC; Interviews with RPN #126, PSW #118, RD, and other staff. (760)

4. A review of resident #003's look back report for food and fluid intake, indicated that there was a change in their intake after they had tested positive for the virus during the outbreak. The progress notes indicated they were assessed by the physician and poor oral intake was noted. A nutritional assessment by the RD was not found on the resident's chart. RN #124 stated that the resident was not eating nor drinking well, and they indicated that an RD assessment or referral was not completed. The RD reviewed the resident's look back report for food and fluid intake, and stated that they should have been involved in addressing the resident's food and fluid intake. The RD confirmed they did not do a nutritional assessment on the resident, when they had a change in their food and fluid intake. There was actual risk of harm to the resident as a nutritional assessment was not completed when they were confirmed to have had a change in their food and fluid intake, resulting in the lack of specific interventions implemented for their nutritional status at that time.

Sources: Resident #003's food and fluid intake on POC, progress notes; Interviews with RN #124, RD, and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents due to the absence of a nutritional assessment completed by the RD, which resulted in the lack of further dietary interventions for the residents when they had a significant change in their health condition.

Scope: The scope of this non-compliance was widespread because the RD did not complete a nutritional assessment for four of the four residents reviewed, when there was a significant change in their health condition.

Compliance History: In the last 36 months, multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 25, 2021(A1)

Order # / No d'ordre: 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with s. 73 (2) of the O. Reg. 79/10.

Specifically, the licensee shall ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that no resident who required assistance with eating or drinking, was served a meal until someone was available to provide the assistance required by the resident.

The MLTC received complaints related to care concerns and staffing crisis that transpired during the home's respiratory outbreak. The DOC indicated that the home's staffing had significantly reduced during the outbreak, which impacted resident care.

RN #119 indicated that around the end of December 2020, due to the home's shortage of front line staff, they were unable to provide assistance to all residents with their breakfast meals, and by the time they reached the remaining residents to assist them with their breakfast, lunch meal trays were beginning to be served. PSW #118 stated that during one of their shifts, due to insufficient staffing, they were unable to let the residents eat and finish their meals at their own pace, as they had to

go and assist the next resident. RPN #115 also stated there were occasions wherein they did not have sufficient staff to help with feeding, so staff were still providing feeding assistance to residents at 2000hrs, for the supper meal trays that were served at 1700hrs. On one occasion, RN #124 stated they walked past resident #011's room close to lunch time, and noted the resident had not received assistance with their breakfast meal. The DOC also stated they observed similar concerns when they were on the floor assisting residents with care, during the home's respiratory outbreak. The DOC also mentioned on one occasion, they went in resident #005's room to provide assistance, and the resident refused to eat their meal as it was already cold. There was actual risk of harm to the residents as meals were being served to them at a time when staff were not available to provide the required assistance, and the delay in assistance compromised the integrity of the food, becoming unpalatable for residents, which may have also potentially lead to a decrease in their food and fluid intake.

Sources: Resident #011's care plan, POC documentation, progress notes; Interviews with the DOC, RNs #119 & #124, PSW #118, RPN #115 and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as meals were being served to them at a time when staff were not available to provide the required assistance, and the delay in assistance compromised the integrity of the food, becoming unpalatable for residents, which may have also potentially lead to a decrease in their food and fluid intake.

Scope: The scope of this non-compliance was widespread because it has affected a large number of the LTCH's residents.

Compliance History: In the last 36 months, multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 25, 2021(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 26th day of February, 2021 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by ROMELA VILLASPIR (653) - (A1)

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