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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TORONTO ON M2M 4K5
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 14, 2020	2020_780699_0012 (A1)	006736-20, 010121-20	Complaint

Licensee/Titulaire de permis

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

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

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

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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

Compliance due date extended to December 11, 2020.

Issued on this 14th day of October, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by PRAVEENA SITTAMPALAM (699) - (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): June 16-19, 22-26, and 30, July 2-3, 6- 9, 2020. Off-site inspection dates July 15, and 17, 2020.

The following complaint logs were inspected during this inspection:

-Log # 006736-20 (Critical Incident System #2945-000014-20) and 010121-20 related to fracture of unknown cause and alleged suspected neglect of resident #010.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Dietitian (RD), Registered Practical Nurse (RPN), Personal support workers (PSW), power of attorney (POA), family members (FM), and residents.

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

policies and procedures.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #010 was assessed using an interdisciplinary approach and that actions were taken and outcomes are evaluated when they had a change of 7.5% per cent of body weight over three months.

The Ministry of Long-term Care (MLTC) received a complaint related to resident #010 experiencing significant weight loss.

Review of resident #010's clinical health record showed that the resident lost an identified amount of weight over the course of six months.

Review of resident #010's progress notes indicated that the resident had a weight change warning of a 7.5% decrease in three months. Further review of the progress note indicated that a referral to the registered dietician (RD) was not needed.

Further review of the care plan and clinical health record did not indicate that interventions were reassessed, or outcomes evaluated when the weight change was noted. Review of progress notes did not indicate that the resident's weight loss was communicated to the RD or physician.

Review of resident #010's clinical health record indicated a referral was sent to the RD related to a change in appetite/intake consistently less than 50% for three

days, twelve days after the weight change warning was noted. The RD noted resident #010's supplement was increased as per physician, therefore no further nutritional recommendations were made.

Record review of resident #010's documentation survey showed that the resident had a further decline of fluid and food intake over a period of seven days. Review of the progress notes did not indicate that the physician or RD were notified of resident #010's decline in oral intake during this time. Upon review of the clinical health record, there was no evaluation of the interventions that were in place. The resident was subsequently started on an identified treatment as they were exhibiting signs and symptoms of identified condition.

Review of resident #010's medication administration record (MAR) indicated that weights were being completed at an identified frequency, however there was no documentation of the resident's weight changes in the progress notes or clinical health record. Please see WN #2 related to s. 6 (9)(1) for further details.

In an interview with RPN #161 , they indicated that if a resident had a change in their weight, such as a 7.5% decrease over three months, a referral to the RD should have been made.

In an interview with RD #108, they indicated that they should have been referred to assess resident #010 for their weight loss.

Record review of the home's policy titled "Monitoring of Resident Weights", policy number VII-G-20.90, last revised April 2019, indicated the following:
-All unplanned weight loss or gain of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days, and other weight change that compromises resident's health status, will be assessed and evaluated, and documented by a member of the interprofessional care team. A RD referral may be required.
-The nurse will investigate potential causes of weight variance, including review of resident's current eating patterns, hospitalizations within the past month, and related symptoms and observations.

In an interview with DOC #102, they indicated they would have expected a referral to the RD to have been completed, re-engaging the physician and revaluation of resident #010 related to their weight loss and decline in oral intake.

The licensee has failed to ensure resident #010 was assessed using an

interdisciplinary approach when they had a change of 7.5% of body weight over three months. There was no referral to the RD, no communication to the physician regarding the weight loss and decreased intake. There were no revisions or reassessment of the resident's plan of care related to weight loss management. The resident was subsequently started on an identified treatment as they were exhibiting signs and symptoms of an identified condition.

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

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Record review of resident #010's medication administration record (MAR) indicated the following:
- check weight at an identified frequency.

Further review of resident #010's MAR showed that weights were being monitored at an identified frequency and were checked as completed, however the weight amount was not documented within the MAR.

Record review of the progress notes, weight assessment tab in PointClickCare (PCC) and clinical health record did not show any documentation of the resident's weight.

In an interview with DOC #102, they indicated that the expectation would be for the weight to be documented in the weight assessment tab in PCC or in the progress notes, so that the weights can be trended.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #3: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #010 was exhibiting altered skin integrity they received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The MLTC received a Critical Incident System (CIS) report related to resident #010 sustaining an injury of unknown cause. A complaint was received related to the pain management for the resident related to the injury.

Record review of the progress note for resident #010, showed that the resident was observed to have an identified altered skin integrity on a specific area of their body. Further review of the progress notes indicated that a skin assessment was done, that no pain was noted on palpation and scheduled pain medication was provided. There was no indication if a pain assessment was completed, or if a physician was notified.

Record review of progress notes showed that on the following day, the resident was assessed related to their identified altered skin integrity. The physician was informed, an x-ray was ordered, and a temporary specified intervention was applied. A pain assessment was also completed which indicated a pain score of 2, indicating mild pain. Resident #010 was observed groaning in pain with decreased range of motion. Pain medication was reviewed with the physician.

In an interview with DOC #102, they indicated that through their investigation of the incident, they had identified that the registered staff working on the day before, failed to appropriately assess resident #010, and they had identified gaps in nursing practice. The DOC indicated that the registered staff did not complete a pain assessment, range of motion assessment or follow up with the physician until the following day, when a pain assessment and medication review by the physician was completed for the resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee has failed to ensure that records of the residents of the home are kept at the home.

The inspector requested the physician communication book for a specific month to review for nurse to physician communication regarding resident #010. The home was unable to locate the physician communication book after multiple requests from the inspector.

In an interview with the DOC, they indicated that it was the expectation to keep any documents related to resident care and acknowledged the physician communication book for an identified month was unable to be located.

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #010 was protected or free from neglect by the licensee or staff in the home.

The Ministry of Long-term Care (MLTC) received a complaint alleging suspected neglect of resident #010.

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

Review of a progress note by the RD indicated that the nursing staff was reminded to refer to the RD for significant concerns such as a decline in intake of meals, snacks, fluids, and supplements.

Review of resident #010's progress notes indicated that the resident had a weight change warning of a 7.5% decrease in three months. Further review of the progress note indicated that a referral to the RD was not completed, nor was there a reassessment of the resident's plan of care related for nutrition. Please refer to WN #1 related to r. 69 for
further details.

Record review of resident #010's documentation survey for an identified month showed that the resident had a decline in fluid and food intake over a seven day period, and fluid intake was consistently below estimated energy requirements determined by the RD.

Record review of resident #010's progress note indicated the physician ordered bloodwork to be completed for the resident. Review of resident #010's clinical health record showed that no bloodwork was completed.

Review of progress notes indicated that the resident was diagnosed with an infection and an identified treatment was initiated. Upon review of resident #010's clinical health chart, there were no progress notes or vital signs to indicate that the resident was monitored for their infection for nine shifts. Please refer to WN #7 related r. 229 (5)(a) for further details.

A referral to the RD for resident #010 was completed for change in appetite/intake consistently less than 50% for three days, requesting assessment for monitoring of dehydration and weight loss. The RD noted resident #010's supplement was increased as per physician's order, therefore no further nutritional recommendations were made. The RD assessed the resident to be at specific nutritional risk. Further review of the progress notes did not indicate that the physician or RD were notified of resident #010's decline in oral intake.

Review of resident #010's care plan with full revision history and clinical health record did not indicate there was a plan of care in place for an identified condition and infection monitoring.

Review of a progress note showed that the physician assessed the resident, and initiated two specified treatments. Further review of the progress notes on an identified date, showed that the physician indicated resident #010 had a poor outcome. Resident #010 subsequently passed away in the home on the same day as the physician's note.

In an interview with RPN #163, they indicated that if a resident was observed with poor oral intake, they would initiate hydration monitoring. This would include monitoring vital signs every shift, assessing for signs of dehydration and document their food and fluid intake throughout the shift. RPN #163 also indicated that they would send referrals to the physician and RD to assess the resident.

In an interview with physician #129, they indicated that if a resident is having poor oral intake, they would be at risk for several different health conditions. They ordered bloodwork for resident #010 to assess for identified conditions. Physician #129 indicated they started the resident on an identified treatment as the resident was exhibiting signs of a specific condition. They further indicated that they could not recall if they were informed of resident #010's poor oral intake and that they would have documented in their progress notes if they were. Physician #129 indicated that it is the expectation that staff notify them if the resident is having poor oral intake, and exhibiting signs of a specific condition.

In an interview with RD #108, they indicated that a referral to the RD would occur if the resident had poor oral intake over a course of a few days, exhibited signs and symptoms of dehydration and if the resident is consuming less than a certain amount of fluids. The RD indicated they had specified that the nursing staff were reminded to refer to the RD if there was any decline to resident #010. RD #108 indicated that they should have referred the resident back to them for reassessment.

In an interview with DOC #102, they indicated it is the expectation that if resident #010 was experiencing decreased oral intake, the staff should be re-evaluating the resident, and collaborating with the RD and physician. They further indicated that staff would be expected to monitor for dehydration and complete an assessment.

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of a neglect investigation were reported to the Director.

The MLTC received a Critical Incident System (CIS) report submitted by the home related to resident #010 sustaining an injury of an unknown cause.

Record review of the CIS indicated that the home's investigation was still ongoing and that the CIS will be amended with the progress and outcome of investigation. Further review of the CIS did not show any results of the investigation.

In an interview with DOC #102, they confirmed that the CIS was not amended with the outcome of the investigation.

WN #7: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitored resident #010 for symptoms of infection on every shift in accordance with evidence-based practices.

Review of progress notes indicated that on a specified date, resident #010 was diagnosed with an infection, and an identified treatment was initiated.

Review of resident #010's progress notes and vital sign assessments in PointClickCare (PCC) indicated that during nine shifts, the resident was not monitored for signs and symptoms of their infection.

In an interview with RPN #173, they indicated that if a resident has an infection, they would be monitored for vital signs, fever, respiratory status and temperature. They indicated that this would occur every shift.

In an interview with DOC #102, they indicated that they would expect a comprehensive assessment of the resident to be done every shift.

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

Issued on this 14th day of October, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PRAVEENA SITTAMPALAM (699) - (A1)
Inspection No. / No de l'inspection :	2020_780699_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006736-20, 010121-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 14, 2020(A1)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kerri Judge

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee must be compliant with s. 69 of O.Reg. 79/10.

Specifically, the licensee must ensure:

1. Any residents exhibiting a change of 5 per cent of body weight, or more, over one month, a change of 7.5 per cent of body weight, or more, over three months, a change of 10 per cent of body weight, or more, over 6 months, or any other weight change that compromises the resident's health status are assessed using an interdisciplinary approach, that actions are taken, outcomes are evaluated and documented.
2. Develop and implement a monthly audit to monitor all residents who exhibit weight changes as indicated above in number one. The audit is to include but not limited to the following information: unit name, resident name, date of audit, person completing the audit, outcome of audit, follow up actions; and any other relevant information.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #010 was assessed using an

interdisciplinary approach and that actions were taken and outcomes are evaluated when they had a change of 7.5% per cent of body weight over three months.

The Ministry of Long-term Care (MLTC) received a complaint related to resident #010 experiencing significant weight loss.

Review of resident #010's clinical health record showed that the resident lost an identified amount of weight over the course of six months.

Review of resident #010's progress notes indicated that the resident had a weight change warning of a 7.5% decrease in three months. Further review of the progress note indicated that a referral to the registered dietician (RD) was not needed.

Further review of the care plan and clinical health record did not indicate that interventions were reassessed, or outcomes evaluated when the weight change was noted. Review of progress notes did not indicate that the resident's weight loss was communicated to the RD or physician.

Review of resident #010's clinical health record indicated a referral was sent to the RD related to a change in appetite/intake consistently less than 50% for three days, twelve days after the weight change warning was noted. The RD noted resident #010's supplement was increased as per physician, therefore no further nutritional recommendations were made.

Record review of resident #010's documentation survey showed that the resident had a further decline of fluid and food intake over a period of seven days. Review of the progress notes did not indicate that the physician or RD were notified of resident #010's decline in oral intake during this time. Upon review of the clinical health record, there was no evaluation of the interventions that were in place. The resident was subsequently started on an identified treatment as they were exhibiting signs and symptoms of identified condition.

Review of resident #010's medication administration record (MAR) indicated that weights were being completed at an identified frequency, however there was no documentation of the resident's weight changes in the progress notes or clinical health record. Please see WN #2 related to s. 6 (9)(1) for further details.

In an interview with RPN #161, they indicated that if a resident had a change in their weight, such as a 7.5% decrease over three months, a referral to the RD should have been made.

In an interview with RD #108, they indicated that they should have been referred to assess resident #010 for their weight loss.

Record review of the home's policy titled "Monitoring of Resident Weights", policy number VII-G-20.90, last revised April 2019, indicated the following:
-All unplanned weight loss or gain of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days, and other weight change that compromises resident's health status, will be assessed and evaluated, and documented by a member of the interprofessional care team. A RD referral may be required.
-The nurse will investigate potential causes of weight variance, including review of resident's current eating patterns, hospitalizations within the past month, and related symptoms and observations.

In an interview with DOC #102, they indicated they would have expected a referral to the RD to have been completed, re-engaging the physician and revaluation of resident #010 related to their weight loss and decline in oral intake.

The licensee has failed to ensure resident #010 was assessed using an interdisciplinary approach when they had a change of 7.5% of body weight over three months. There was no referral to the RD, no communication to the physician regarding the weight loss and decreased intake. There were no revisions or reassessment of the resident's plan of care related to weight loss management. The resident was subsequently started on an identified treatment as they were exhibiting signs and symptoms of an identified condition.

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

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

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

Issued on this 14th day of October, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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