Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 10, 2016	2015_320612_0025	024294-15	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

SARAH CHARETTE (612), MARIE LAFRAMBOISE (628)

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): November 25, 26 and 27, 2015

This Complaint Inspection is related to three complaints received by the Ministry, one related to falls, one related to insufficient staffing and one related to dietary and resident care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), three Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Dietitian, the Manager of Dietary Services, the Kinesiologist, residents' family members and Residents.

The inspector(s) conducted a daily walk through of common areas, observed the provision of care to residents, observed staff to resident interactions, reviewed various policies and procedures and reviewed clinical records, complaint reports and critical incident reports.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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 plan of care set out clear directions to staff and others who provided direct care to the resident.

Inspector #612 observed resident #004 on November 25 and November 26, 2015 and noted that the staff fed the resident a specific diet consistency.

A review of resident #004's plan of care revealed that the resident will at times eat a different diet consistency than the inspector observed.

An interview with PSW #107 and PSW #109 confirmed that resident #004 was fed a specific diet consistency and that the resident did not eat the other diet consistency listed in their plan of care.

A member of the interdisciplinary team stated to the Inspector during an interview that resident #004 will eat limited food items on their own, however confirmed that the intervention listed in the care plan was not clear to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Inspector #612 interviewed a member of the interdisciplinary team on November 25, 2015. They stated that resident #003 had completed a trial with adaptive aids to assist the resident to be independent with eating. The member of the interdisciplinary team stated that they were unable to comment on the trial as they were unable to locate any further documentation in the resident's plan of care.

A review of resident #003's clinical records revealed a progress note from October, 2015, completed by a member of the interdisciplinary team, which stated that the trial of the adaptive aid had shown benefit during meals. Resident #003 was in agreement to continue with the use of the adaptive aid. There was no documentation in the resident's plan of care providing direction to the staff to utilize the adaptive aids.

Observations conducted on November 25, 2015 during breakfast and lunch service revealed that resident #003 was not using the adaptive aids.

On November 26, 2015 during dinner service, the Inspector observed the dietary staff place the adaptive aids at resident #003's place setting. Moments later they were removed under the direction of a Manager as there was no documentation in resident #003's plan of care related to utilizing the adaptive aids.

An interview with RPN #114 revealed that resident #003 always used the adaptive aids during supper, however they were unable to locate where this information was in the resident's plan of care. The Inspector interviewed RPN #108 and PSW #109 who stated that resident #003 did not use the adaptive aids. During an interview with a Manager and a member of the interdisciplinary team, they were unable to confirm if resident #003 should be using the adaptive aids. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Inspector #612 reviewed resident #001's clinical record and noted that the resident had experienced a weight loss of 31.9% over a 6 month period.

Observations made on November 25 and 26, 2015 revealed that staff used various techniques to feed resident #001.

The Inspector interviewed PSW #107, PSW #109, RPN# 108 and RPN #114 who provided various examples of interventions used to encourage resident #001 to eat, however agreed the interventions were not all in the written plan of care.

An interview with a member of the interdisciplinary team revealed that they were not aware of all the interventions used to encourage resident #001 to eat and confirmed that this information was not in the resident's written plan of care.

An interview with the ADOC #117 revealed that the nursing staff and another member of the interdisciplinary team did not collaborate in the development and implementation of resident #001's plan of care. [s. 6. (4) (b)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #612 observed resident #003 on November 25, 2015 during breakfast and lunch service and on November 26, 2015 during dinner service and noted the following:

- On November 25, 2015 during breakfast, the Inspector observed resident #003 eating independently with a specific utensil at their place setting.

- During lunch on November 25, 2015, the Inspector observed resident #003 with a specific utensil at their place setting. The Inspector observed the resident struggling to eat independently. A PSW approached the resident and asked if they required assistance, resident #003 accepted. The PSW fed the resident with another specific utensil.

A review of resident #003's plan of care revealed that a member of the interdisciplinary team had recommended not to use the two specific utensils that the Inspector had observed the resident using. The member of the interdisciplinary team had recommended a different utensil for the resident to use.

An interview with a member of the interdisciplinary team and ADOC #117 confirmed that staff did not provide care as per the plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in resident #003's plan of care is provided to resident #003 as specified in the plan, to be implemented voluntarily.

WN #2: 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 residents with the weight changes identified in O.Reg 79/10, s.69. 1.,s.69. 2.,s.69. 3.,s.69. 4., were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

A review of resident #003's weights in Point Click Care (PCC) revealed that the resident had an 8.3% decrease in their weight over a two month period.

Inspector #612 reviewed resident #003's clinical record. In mid November, 2015 a referral was sent to a member of the interdisciplinary team related to resident #003's weight loss. The progress note, which RN #118 completed on the same day as the

referral, stated that a note was left for the physician to review the resident's weight loss, a referral was sent to a member of the interdisciplinary team, the resident's Substitute Decision Maker was notified and the resident's care plan was reviewed and updated related to the weight variance.

A review of resident #003's most recent plan of care did not include any interventions or revisions to address the resident's 8.3% weight loss in two months.

Inspector #612 interviewed RN #118, who was unable to identify any interventions in the plan of care that addressed the resident's recent weight loss.

An interview with a member of the interdisciplinary team revealed that they had been seeing the resident monthly related to another concern. Resident #003 had also been seen by the another member of the interdisciplinary team as well. The Inspector confirmed that the two members of the interdisciplinary team had assessed the resident related to the other concern, however resident #003's weight loss was not specifically assessed.

The Inspector interviewed a member of the interdisciplinary team, RN#118 and ADOC #117 who stated that there was no official time line for referral of residents to the Dietary team when they had triggered a weight variance, however they confirmed that as soon as the weight was entered in PCC, the system would alert staff of any weight variance.

A review of the home's policy titled Nutritional Assessments, DS-04-01-03 revealed that nutritional assessments are to be completed for every resident upon admission and whenever a significant change in the resident's health condition has nutritional implications. The nutritional assessments are to be completed in accordance with provincial legislation. A member of the interdisciplinary team, ADOC #117 and RN #118 confirmed that this included a significant weight change of 5% in one month, 7.5% in three months and 10% in six months.

Despite a significant weight loss by resident #003, the resident was not assessed using an interdisciplinary approach nor were actions taken to address the significant weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee has failed to ensure that residents with the weight changes identified in O.Reg 79/10, s.69. 1.,s.69. 2.,s.69. 3.,s.69. 4., were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Inspector #612 reviewed resident #001's weight record in Point Click Care (PCC). The Inspector noted that the resident had experienced a significant weight loss over a six month period.

A review of resident #001's health care record revealed the following:

In May, 2015, the resident's weight did not trigger in PCC for a weight loss.

In June, 2015, the resident's weight triggered in PCC as a 13% weight loss in one month.

In July, 2015, the resident's weight triggered in PCC as a 12.5% weight loss over two months.
- During an interview with a member of the interdisciplinary team, they confirmed that no interventions were implemented because resident #001 had a 0.5% weight gain between June and July.

In August, 2015, the resident's weight triggered in PCC as an 11.5% weight loss in one month.
- A member of the interdisciplinary team and RN #118 confirmed that no referral was completed to the Dietary team this month and the resident's weight loss was not assessed.

In September, 2015, the resident's weight triggered in PCC as a 14.2% weight loss over two months.
- A member of the interdisciplinary team ordered a supplement due to a verbal referral received, that the resident had decreased intake over a period of a couple of days. The member of the interdisciplinary team did not address resident #001's 14.2% weight loss trigger.
- A referral was sent to the member of the interdisciplinary team later in the month regarding the resident's 14.2% weight loss over two months. The member of the interdisciplinary team had documented in a progress note that no further changes or interventions were attempted.

In October, 2015 the resident's weight triggered in PCC as a 15.4% weight loss over three months.
- A trail of another food texture was initiated, the evening shift staff experienced difficulty feeding the resident and reported that the resident was more successful with a different

texture.
- A member of the interdisciplinary team wrote a progress note stating that resident #001's diet can continue as the specific texture and staff can downgrade to the other texture if the resident was not eating well.

In November, 2015, the resident's weight triggered in PCC as a 15% weight loss over four months.
- A referral was completed to a member of the interdisciplinary team to address the significant weight loss.
- The member of the interdisciplinary team assessed resident #001 and noted that the resident experienced a 0.4% weight gain from their October weight, however acknowledged that the resident remained below their goal weight range. The member of the interdisciplinary team stated that no further changes were required to the current interventions.

An interview with RN #118 revealed that the resident was on a 'weight increasing plan'. The RN stated that when there was a triggered weight change, they are to complete a referral to the Dietary team. The RN was unable to locate any referral during the month of August when the resident had experienced a significant weight loss in one month.

During an interview with a member of the interdisciplinary team, they confirmed that a referral was not completed and no actions were taken in regards to resident #001's weight loss from July to August, 2015. They stated that resident #001 was not on a 'weight increasing plan' as that does not exist, the plan of care for each resident was supposed to be tailored to the individual. The Inspector questioned a specific intervention the staff were implementing and the member of the interdisciplinary team was unable to comment as they were unable to find that intervention in the resident's plan of care.

A review of the home's policy titled Nutritional Assessments, DS-04-01-03 revealed that nutritional assessments are to be completed for every resident upon admission and whenever a significant change in the resident's health condition has nutritional implications. The nutritional assessments are to be completed in accordance with provincial legislation. A member of the interdisciplinary team, ADOC #117 and RN #118 confirmed that this included a significant weight change of 5% in one month, 7.5% in three months and 10% in six months.

Despite continuous and significant weight loss over a six month period, resident #001 was not assessed using an interdisciplinary approach, nor were actions taken to address

their weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

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

Issued on this 16th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH CHARETTE (612), MARIE LAFRAMBOISE (628)
Inspection No. / No de l'inspection :	2015_320612_0025
Log No. / Registre no:	024294-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 10, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE FALCONBRIDGE 281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Louise Arbour

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee will ensure that:

a) the nursing staff and other members of the interdisciplinary team collaborate with each other in their assessments of resident #001 and #003, so that they are integrated and consistent with and complement each other;

b) a plan of care is developed and implemented for resident #001 and #003 related to weight changes and nutritional care so that the different aspects of care are integrated and consistent with and complement each other.

Grounds / Motifs :

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

Inspector #612 reviewed resident #001's clinical record and noted that the resident had experienced a weight loss of 31.9% over a 6 month period.

Observations made on November 25 and 26, 2015 revealed that staff used various techniques to feed resident #001.

The Inspector interviewed PSW #107, PSW #109, RPN# 108 and RPN #114 who provided various examples of interventions used to encourage resident #001 to eat, however agreed the interventions were not all in the written plan of care.

An interview with a member of the interdisciplinary team revealed that they were not aware of all the interventions used to encourage resident #001 to eat and confirmed that this information was not in the resident's written plan of care.

An interview with the ADOC #117 revealed that the nursing staff and another member of the interdisciplinary team did not collaborate in the development and implementation of resident #001's plan of care. (612)

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Inspector #612 interviewed a member of the interdisciplinary team on November 25, 2015. They stated that resident #003 had completed a trial with adaptive aids to assist the resident to be independent with eating. The member of the interdisciplinary team stated that they were unable to comment on the trial as they were unable to locate any further documentation in the resident's plan of care.

A review of resident #003's clinical records revealed a progress note from October, 2015, completed by a member of the interdisciplinary team, which stated that the trial of the adaptive aid had shown benefit during meals. Resident #003 was in agreement to continue with the use of the adaptive aid. There was no documentation in the resident's plan of care providing direction to the staff to utilize the adaptive aids.

Observations conducted on November 25, 2015 during breakfast and lunch service revealed that resident #003 was not using the adaptive aids.

On November 26, 2015 during dinner service, the Inspector observed the dietary staff place the adaptive aids at resident #003's place setting. Moments later they were removed under the direction of a Manager as there was no documentation in resident #003's plan of care related to utilizing the adaptive aids.

An interview with RPN #114 revealed that resident #003 always used the adaptive aids during supper, however they were unable to locate where this information was in the resident's plan of care. The Inspector interviewed RPN #108 and PSW #109 who stated that resident #003 did not use the adaptive aids. During an interview with a Manager and a member of the interdisciplinary team, they were unable to confirm if resident #003 should be using the adaptive aids.

The decision to issue this compliance order was based on the actual harm/risk to residents due to their significant weight loss and the scope which was a pattern as it involved two of the three residents that the Inspector observed during the inspection. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 24, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 :

1. The licensee will ensure that residents #001 and #003 are assessed by the members of the interdisciplinary team, using an interdisciplinary approach related to the weight loss.

2. The licensee will ensure that actions are taken based on the interdisciplinary assessments.

3. The licensee will ensure that the outcomes specific to these residents and their weight loss are evaluated so that changes can be made as required.

Grounds / Motifs :

1. The licensee has failed to ensure that residents with the weight changes identified in O.Reg 79/10, s.69. 1.,s.69. 2.,s.69. 3.,s.69. 4., were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Inspector #612 reviewed resident #001's weight record in Point Click Care (PCC). The Inspector noted that the resident had experienced a significant weight loss over a six month period.

A review of resident #001's health care record revealed the following:

In May, 2015, the resident's weight did not trigger in PCC for a weight loss.

In June, 2015, the resident's weight triggered in PCC as a 13% weight loss in one month.

In July, 2015, the resident's weight triggered in PCC as a 12.5% weight loss over two months.
- During an interview with a member of the interdisciplinary team, they confirmed that no interventions were implemented because resident #001 had a 0.5% weight gain between June and July.

In August, 2015, the resident's weight triggered in PCC as an 11.5% weight loss in one month.
- A member of the interdisciplinary team and RN #118 confirmed that no referral was completed to the Dietary team this month and the resident's weight loss was not assessed.

In September, 2015, the resident's weight triggered in PCC as a 14.2% weight loss over two months.
- A member of the interdisciplinary team ordered a supplement due to a verbal referral received, that the resident had decreased intake over a period of a couple of days. The member of the interdisciplinary team did not address resident #001's 14.2% weight loss trigger.
- A referral was sent to the member of the interdisciplinary team later in the month regarding the resident's 14.2% weight loss over two months. The member of the interdisciplinary team had documented in a progress note that no further changes or interventions were attempted.

In October, 2015 the resident's weight triggered in PCC as a 15.4% weight loss over three months.
- A trail of another food texture was initiated, the evening shift staff experienced difficulty feeding the resident and reported that the resident was more successful with a different texture.
- A member of the interdisciplinary team wrote a progress note stating that resident #001's diet can continue as the specific texture and staff can downgrade to the other texture if the resident was not eating well.

In November, 2015, the resident's weight triggered in PCC as a 15% weight loss over four months.
- A referral was completed to a member of the interdisciplinary team to address the significant weight loss.
- The member of the interdisciplinary team assessed resident #001 and noted that the resident experienced a 0.4% weight gain from their October weight, however acknowledged that the resident remained below their goal weight range. The member of the interdisciplinary team stated that no further changes were required to the current interventions.

An interview with RN #118 revealed that the resident was on a 'weight increasing plan'. The RN stated that when there was a triggered weight change, they are to complete a referral to the Dietary team. The RN was unable to locate any referral during the month of August when the resident had experienced a significant weight loss in one month.

During an interview with a member of the interdisciplinary team, they confirmed that a referral was not completed and no actions were taken in regards to resident #001's weight loss from July to August, 2015. They stated that resident #001 was not on a 'weight increasing plan' as that does not exist, the plan of care for each resident was supposed to be tailored to the individual. The Inspector questioned a specific intervention the staff were implementing and the member of the interdisciplinary team was unable to comment as they were unable to find that intervention in the resident's plan of care.

A review of the home's policy titled Nutritional Assessments, DS-04-01-03 revealed that nutritional assessments are to be completed for every resident upon admission and whenever a significant change in the resident's health condition has nutritional implications. The nutritional assessments are to be completed in accordance with provincial legislation. A member of the interdisciplinary team, ADOC #117 and RN #118 confirmed that this included a significant weight change of 5% in one month, 7.5% in three months and 10% in six months.

Despite continuous and significant weight loss over a six month period, resident #001 was not assessed using an interdisciplinary approach, nor were actions taken to address their weight change. (612)

2. The licensee has failed to ensure that residents with the weight changes

identified in O.Reg 79/10, s.69. 1.,s.69. 2.,s.69. 3.,s.69. 4., were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

A review of resident #003's weights in Point Click Care (PCC) revealed that the resident had an 8.3% decrease in their weight over a two month period.

Inspector #612 reviewed resident #003's clinical record. In mid November, 2015 a referral was sent to a member of the interdisciplinary team related to resident #003's weight loss. The progress note, which RN #118 completed on the same day as the referral, stated that a note was left for the physician to review the resident's weight loss, a referral was sent to a member of the interdisciplinary team, the resident's Substitute Decision Maker was notified and the resident's care plan was reviewed and updated related to the weight variance.

A review of resident #003's most recent plan of care did not include any interventions or revisions to address the resident's 8.3% weight loss in two months.

Inspector #612 interviewed RN #118, who was unable to identify any interventions in the plan of care that addressed the resident's recent weight loss.

An interview with a member of the interdisciplinary team revealed that they had been seeing the resident monthly related to another concern. Resident #003 had also been seen by the another member of the interdisciplinary team as well. The Inspector confirmed that the two members of the interdisciplinary team had assessed the resident related to the other concern, however resident #003's weight loss was not specifically assessed.

The Inspector interviewed a member of the interdisciplinary team, RN#118 and ADOC #117 who stated that there was no official time line for referral of residents to the Dietary team when they had triggered a weight variance, however they confirmed that as soon as the weight was entered in PCC, the system would alert staff of any weight variance.

A review of the home's policy titled Nutritional Assessments, DS-04-01-03 revealed that nutritional assessments are to be completed for every resident upon admission and whenever a significant change in the resident's health

condition has nutritional implications. The nutritional assessments are to be completed in accordance with provincial legislation. A member of the interdisciplinary team, ADOC #117 and RN #118 confirmed that this included a significant weight change of 5% in one month, 7.5% in three months and 10% in six months.

Despite a significant weight loss by resident #003, the resident was not assessed using an interdisciplinary approach nor were actions taken to address the significant weight loss.

The decision to issue this compliance order was based on the actual harm/risk to residents due to their significant weight loss and the scope which was a pattern as it involved two of the three residents that the inspector observed during the inspection. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 24, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 10th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Charette

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