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
Jul 06, 2021	2021_714673_0006 (A1)	017595-20, 019444-20, 021055-20, 021056-20, 021057-20, 021058-20, 025013-20	Critical Incident System

Licensee/Titulaire de permis

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

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

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

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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 26-30, May 3-7,

and May 10-11, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

-Log #017595-20, CIS #2969-000016-20, related to abuse and responsive behaviours

-Log #025013-20, CIS #2969-000030-20, related to falls prevention

-Log #019444-20, Follow-up to CO#001 from inspection #2020_766500_0008

-Log #021055-20, Follow-up to CO#001 from inspection #2020_766500_0007

-Log #021056-20, Follow-up to CO#002 from inspection #2020_766500_0007

-Log #021058-20, Follow-up to CO#003 from inspection #2020_766500_0007, and

-Log #021057-20, Follow-up to CO#004 from inspection #2020_766500_0007.

This inspection was conducted concurrently with inspection #2021_714673_0005.

During the course of the inspection, the inspector(s) spoke with Food Service Aides, RAI-MDS Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitians (RD), Dietary/Nutrition Manager, Housekeeping staff, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Practitioner (NP), Residents, and Family Members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.
6 WN(s)
2 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #004	2020_766500_0007	763
O.Reg 79/10 s. 26. (4)	CO #001	2020_766500_0007	673
O.Reg 79/10 s. 36.	CO #002	2020_766500_0007	673
O.Reg 79/10 s. 72. (3)	CO #003	2020_766500_0007	763

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

(A1)
1. This finding of non-compliance under LTCHA 2007, c. 8, s. 6 (10) (b). was rescinded. [s. 6. (10) (b)]

2. The licensee has failed to ensure that when a resident was being reassessed because care set out in the plan of care was not effective, different approaches were considered in the revision of the plan of care.

The resident was observed sitting in a dining chair in an unsafe position, and engaging in unsafe behaviour. Staff indicated that the resident has been transferring themselves into this position for several weeks despite staff discouragement. The registered nurse on the floor also indicated that if this behaviour was typical for them, staff needed to monitor the resident more closely as they were at risk for falls.

The resident had a previous fall which resulted in an injury and significant change in condition, and change in mobility status. Staff interviews and records indicated that the resident had recent falls as a result of an identified behaviour.

Staff reported that the resident's fall risk may have been reduced by a specified falls intervention, though this was not trialed in the past.

The home's physiotherapist (PT) was aware of the resident's identified behaviour. They reached out to their medical device provider regarding finding a mobility aid which was safer for the resident, though this had not been carried out at the time of inspection. The specified falls intervention was trialed for the resident, but the PT could not recall why it had been discontinued. The physiotherapist agreed this intervention should have been trialed again as a falls prevention strategy.

Sources: observations, resident clinical records (PointClickCare profile, care plan, progress notes), staff interviews (PSW #121, RN #118, RN #115, PT #123, DOC #113). [s. 6. (11) (b)]

Additional Required Actions:

(A1)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 001

WN #2: 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 protect resident #002 from physical abuse by resident #019.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident".

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report from the home that detailed a physical altercation between resident #002 and #019. A verbal altercation followed by a physical altercation took place in the hallway and both residents fell on the floor with resident #002 complaining of pain. Resident #002 was further assessed in the hospital, received surgical intervention for an injury, and had a significant change in their condition after the incident.

Clinical records indicated that both residents exhibited identified responsive behaviours that increased the likelihood for the above incident to occur. Staff were to approach the residents without arguing or condemning them, with awareness of their personal space.

Sources: resident #002 and #019's clinical records (PointClickCare profile, care plan, progress notes), CIS #2969-000016-20, home's investigation notes, staff interviews (PSW #120, RN #118). [s. 19. (1)]

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 there was a system to monitor and evaluate the fluid intake of residents with identified risks related to hydration.

Review of the home's policy titled Hydration Program, #NCM 02-01-12, revised

January 1, 2020, indicated that the system in place to document and monitor intake of all fluids in order to evaluate residents' hydration status included:
-Fluid totals calculated daily by registered staff to ensure each resident receives required intake of fluids; and that the Point of Care (POC) entries calculate fluid totals automatically
-The Food and Fluid Intake Monitoring Record form indicates total fluids obtained per 24 hours, where fluids are documented in milliliters (mL).
-Staff responsible for completing the Food and Fluid Intake Monitoring Record forms are aware of specific volumes of containers used to serve fluids in order to accurately calculate resident fluid intake.
-Guidelines are available for staff and these guidelines are reviewed on a regular basis, especially when changes to glass, mug and/or cup sizes are made.
-Guidelines may be kept for staff reference at the front of the food and fluid recording books or printed on the actual recording forms, or posted near the tablets for the POC system.

i) The home was not using the Food and Fluid Intake Monitoring Record, rather documenting fluid intake in POC. The POC system directed staff to document fluid intake in "cups", whereas the policy indicated to document the intake in mL. Neither clearly indicated the volume in ml in a "cup".

Residents #020, #023, #024's fluid intake records showed that some staff were documenting in "cups" while others were documenting in mLs.

Resident #024 was not on fluid restriction.

Resident #023 was noted to be on a fluid restriction. PSW #103 who provided care to resident #023 had served fluids in Styrofoam cups to resident #023 but they did not know how many "cups" or mLs it equated to. PSW #103 defined one "cup" as 100mL, which would be documented as 1 in PCC, and if a resident had 125mL, it could be recorded in PCC in mLs. RPN #122 who provided care to resident #023 stated that staff were to document in mLs in PCC, not cups.

Resident #020 was noted to be on a fluid restriction. RPN #112 who provided care to this resident did not know whether staff were documenting in cups or in mLs in PCC. PSW #128 and RPN #112 stated that one "cup" in PCC was 250mL, whereas RPN #129 stated that it was equivalent to 125mL.

The RD's interpretation of one cup was 125mL. The RD acknowledged the

inconsistency in the hydration system as it relates to staff documenting and monitoring residents' fluid intakes.

ii) RPN #129 and RPN #112 provided an undated handwritten note to inspector #673 indicating resident #020 was on fluid restrictions and how many mLs of fluids to provide at meals and snacks, but the document did not clarify specific volumes of containers. They stated this was the only guidance document provided to them.

The DOC and ADOC acknowledged the lack of a consistent system for tracking fluid intake and that this might pose a risk to residents, especially those with identified hydration risks such as fluid restrictions, when unable to appropriately and consistently monitor and evaluate their fluid intake.

Sources: Review of resident #020, 023, and #024’s fluid intake records and plans of care, home’s policy titled Hydration Program, PSW #103, PSW #128, RPN #122, RPN #112, RPN #129, RD #133 [s. 68. (2) (d)]

Additional Required Actions:

(A1)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 003

(A1)
The following Voluntary Plan of Correction will be issued.

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 Nutrition Care and Hydration programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to resident #003 under the falls prevention program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report detailing a fall of resident #003. The resident was sent to hospital for further assessment where they received treatment for their injuries.

The resident had a history of falls of a similar nature, where they engaged in an identified behaviour and fell. Since the incident, resident #003 fell once more by engaging in this same behaviour.

Staff reported that resident #003 was at risk for falls due to this identified behaviour. They remembered that two identified falls interventions had been implemented after the resident returned from hospital, but were not sure why these interventions were no longer in place. They indicated these two identified

interventions might have been effective fall intervention strategies.

The PT indicated that one of the falls interventions identified by staff was implemented for resident #003 but the resident learned how to disengage it and it was discontinued. There was no written record of assessment of the effectiveness of this intervention as a falls intervention for resident #003, or the resident's responses to that intervention. The PT thought they added the other identified falls intervention to the resident's plan of care after the resident returned from the hospital. They believed they removed the intervention after the resident's condition changed and the intervention became a hazard.

Sources: resident clinical records (PointClickCare profile, care plan, progress notes), CIS #2969-000030-20, home's investigation notes, staff interviews (PSW #126, PT #123, DOC #113). [s. 30. (2)]

2. The licensee has failed to ensure that any actions taken with respect to resident #002 under the falls prevention program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The resident was observed sitting in a dining chair in an unsafe position, and engaging in unsafe behaviour. Staff indicated that resident #002 has been transferring themselves into this position for several weeks despite staff discouragement. The registered nurse on the floor also indicated that if this behaviour was typical for them, staff needed to monitor the resident more closely.

The resident used a mobility aid for locomotion, and had a history of frequent falls in the home. Staff interviews and records indicated that the resident had recent falls as a result of an identified behaviour.

Staff reported that additional falls interventions may be of benefit to decrease their risk for falls and injury. They were not sure if an identified falls intervention was trialed in the past; however, they felt it was a good intervention to trial given the resident's identified behaviour. The registered nurse did not recall if this specified intervention or any other additional intervention was trialed to manage their risk.

The home's PT was aware of resident #002's identified behaviour and reached out to the medical device provider regarding finding a safer mobility aid, and were awaiting follow-up. An identified falls intervention was trialed for the resident; however, no documentation of an assessment of the effectiveness or the

resident's response to the intervention was completed. Since the inspector observed the above behaviour, staff requested the identified falls intervention be trialed to lower the risk of falls for the resident. The physiotherapist susequently added this identified falls intervention into the resident's care plan but no accompanying assessment notes were seen in the resident's clinical records for the addition of this intervention.

Sources: observations, resident clinical records (PointClickCare profile, care plan, progress notes), staff interviews (PSW #121, RN #118, RN #115, PT #123, DOC #113). [s. 30. (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 a system to monitor and evaluate the fluid intake of residents with identified risks related to hydration, to be implemented voluntarily.

WN #5: 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 the Guide to Weight Gain/Loss procedure included in the required Nutrition Care and Hydration Program was complied with, for resident #023.

LTCHA s.11 (1)(a) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

O. Reg. 79/10, s. 68 (2)(e) requires that the program includes a weight monitoring system to measure and record with respect to each resident weight on admission and monthly thereafter.

The home's system included the home's procedure " Guide to Weight Gain/Loss", which staff did not comply with.

The guide indicated that when a difference of 2 kilograms (kg) or other significant weight change was noted from the previous month's weight, the resident should be re-weighed. Once the weight change was confirmed, a referral to the RD was required.

The resident's weight increased from 66.2kg to 94.8kg in an identified period of one month, and the following month, it was noted to be 94.6kg. There was no referral made to the RD in during these two months for these weight changes, and there was no re-weigh completed.

The RD assessed the resident during the second month of weight change, related to improved intake and supplementation. They queried the accuracy of the weight, but did not request a re-weigh.

The resident was reweighed in the following month, and was found to be 69kg.

The RD acknowledged that nursing staff should have made a referral for the significant change in weight in during the first two months or reweighed the resident in if an error in weight was suspected. The RD acknowledged that the home's process for weight monitoring was not followed.

Sources: Guide to Weight Gain/Loss document, PCC weight records, RD referrals, RD [s. 8. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2020_766500_0008 served on September 18, 2020, with a compliance due date of December 18, 2020.

The required care plan auditing process for residents who had changes in their continence care needs was not fully implemented.

Review of the home’s compliance order documents did not include audits specific to when residents had a change in continence care needs.

The ADOC and DOC acknowledged that the audits they had completed were not done specifically for residents with changes in condition related to continence.

Sources: Inspection report #2020_766500_0008, ADOC, DOC, home’s compliance order documents [s. 101. (3)]

Issued on this 6 th day of July, 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 PRAVEENA SITTAMPALAM (699) - (A1)
Inspection No. / No de l'inspection :	2021_714673_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	017595-20, 019444-20, 021055-20, 021056-20, 021057-20, 021058-20, 025013-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 06, 2021(A1)
Licensee / Titulaire de permis :	Villa Colombo Seniors Centre (Vaughan) Inc. 10443 Highway 27, Kleinburg, Vaughan, ON, L0J-1C0
LTC Home / Foyer de SLD :	Villa Colombo Seniors Centre (Vaughan) 10443 Highway 27, Kleinburg, Vaughan, ON, L0J-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Fiorinta Flammia

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

(A1)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001

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

Linked to Existing Order/ Lien vers ordre existant : 2020_766500_0008, CO #001;

Pursuant to / Aux termes de :

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must comply with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1).

Specifically, the licensee shall ensure that resident #002, is protected from physical abuse by resident #019.

Grounds / Motifs :

1. The licensee has failed to protect resident #002 from physical abuse by resident #019.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident".

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report from the home that detailed a physical altercation between resident #002 and #019. A verbal altercation followed by a physical altercation took place in the hallway and both residents fell on the floor with resident #002 complaining of pain. Resident #002 was further assessed in the hospital, received surgical intervention for an injury, and had a significant change in their condition after the incident.

Clinical records indicated that both residents exhibited identified responsive behaviours that increased the likelihood for the above incident to occur. Staff were to approach the residents without arguing or condemning them, with awareness of their personal space.

Sources: resident #002 and #019's clinical records (PointClickCare profile, care plan, progress notes), CIS #2969-000016-20, home's investigation notes, staff interviews (PSW #120, RN #118).

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

Severity: A resident physically abused another resident causing actual harm to the resident.

Scope: This was an isolated case as one out of the three residents reviewed was not protected from abuse.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1). Five written notifications (WNs) and two compliance orders (COs) were issued to the home related to s. 19 (1). (763)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 06, 2021

(A1)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

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).

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 6 th day of July, 2021 (A1)

Signature of Inspector / Signature de l'inspecteur :

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

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