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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 6, 2016	2016_431527_0017	030119-16	Resident Quality Inspection

Licensee/Titulaire de permis

488491 ONTARIO INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

AVALON RETIREMENT CENTRE
355 BROADWAY AVENUE ORANGEVILLE ON L9W 3Y3

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

KATHLEEN MILLAR (527), HEATHER PRESTON (640), MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 17, 18, 19, 20, 21, 24, 25 and 26, 2016

During the course of this inspection the following Critical Incidents and Complaints were inspected:

Critical Incidents:
Log #012584-15 related to resident transfer;
Log #031389-15 related to resident fall;
Log #021883-16 related to resident fall;
Log #023789-16 related to resident missing;
Log #026344-16 related to improper transfer of resident; and
Log #027987-16 related to resident fall.

Complaints:
Log #025282-15 related to environmental temperature and dining/snack service;
Log #035000-15 related to medication administration, fall and hydration;
Log #012824-16 related to staff to resident verbal abuse; and
Log #023047-16 related to resident care.

During the course of the inspection, the inspector(s) spoke with the residents, family members, the President of the Residents' Council, the President of the Family Council, the Administrator, The Director of Care (DOC), the co-Director of Care, the Registered Dietitian (RD), the Nutrition Manager, the Restorative Care Coordinator (RCC)/Falls Lead, the Staff Educator, the Resident & Family Services Coordinator, the Administrative Assistant, the Behavioural Support Officer (BSO)/Manager, the Environmental Manager, the Nurse Practitioner, the Physiotherapist, the Wound & Skin Care Nurse, the Registered staff, the Personal Support Workers (PSWs), housekeepers, dietary aides and the physiotherapy aide

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **10 VPC(s)**
- **0 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. (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 failed to ensure that there was a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

Resident #141 was assessed in December, 2015, as being continent. When the clinical record was reviewed, the written plan of care identified the resident had bowel incontinence and bladder continence. The Personal Support Worker (PSW) #331 indicated that resident #141 was incontinent of both bowel and bladder, and the resident was wearing containment briefs for incontinence. The resident was discharged from the home and could not be observed during this inspection; however the resident's Substitute Decision Maker (SDM) was interviewed and indicated that they were upset that the resident was in a continence product, and had lost their independence and dignity. When reviewing the written plan of care with PSW #331 and #332, both the PSWs identified that what was documented on the written plan of care for the resident's bowel and bladder continence was confusing and didn't provide clear direction. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care for residents was provided to the residents as specified in the plan.

A) Resident #041 had a plan of care that directed staff to implement special wound and skin precautions, to offload pressure. In October, 2016, the resident was observed in the lounge. The resident did not have the wound and skin precautions applied. Registered staff #320 and PSW #321 confirmed that the resident was required to have the wound and skin precautions applied all the time. PSW #321 stated that it was not their regular

staff providing care that day; however, the resident's written plan of care and kardex clearly identified the resident's wound and skin care needs.

B) Resident #141 was admitted to the home in November, 2015. The resident was assessed by the Community Care Access Centre (CCAC), which identified resident #141 was continent. The resident's SDM informed the home upon admission that the resident went to the toilet on their own, and that they did not have any accidents. The home conducted a Continence Assessment in December, 2015, which also identified the resident was continent and they did not wear any containment product. The written plan of care identified that the resident required some assistance for safety and resident #141 was continent. The daily voiding record was reviewed, which indicated the resident was using the toilet; however on the resident's first night in the home, the registered staff #335 indicated on the progress notes that the resident was incontinent and was wearing a containment product.

The resident's SDM was interviewed and stated that when the family came in to visit the next day after admission, they were upset because the resident was in a containment product and the resident had no problems going to the bathroom before they came into the home. Registered staff #325 was interviewed and stated that the resident was incontinent and was wearing briefs. Registered staff #330 was interviewed and also identified the resident was incontinent from what they recalled. When the continence assessment and the written plan of care were reviewed with the registered staff, they indicated that if the resident was continent they should not have been wearing briefs and should have been on the nursing restorative program for continence to maintain their abilities. The DOC was interviewed and confirmed the resident was not provided with care as provided for in the plan. (527) [s. 6. (7)]

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 o ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care; to ensure that the residents are given an opportunity to participate fully in the development and implementation of their plan of care; and to ensure that the care set out in the plan of care is provided to residents as specified in their plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy, "Resident Rights, Care and Services - Abuse", revised March, 2015, identified infantilization as emotional abuse. The policy directed staff to document in writing all factual events witnessed during the abusive situation, including verbal interactions, non-verbal interactions, physical interactions and any other information that may be helpful in investigating the situation. The policy also identified that if the person identified was a staff member they would be placed off work with pay pending investigation of the situation.

The policy directed staff to initiate a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC), assess the residents condition, document the incident, and all conversations. The Administrator and DOC were to initiate the investigation checklist, and implement an internal investigation of the allegations of abuse, utilizing the “Resident Rights, Care and Services – Administration Investigation Checklist”, interview the resident, other residents, and any other person who may have any knowledge of the situation. If statements had been written, interview those persons completing the statements after the statement had been written. Interview the accused and document same in meeting minutes.

Documentation in resident #072's progress notes in August, 2016, identified concerns voiced by family members of the resident in relation to the way a staff member spoke to the resident. The Director of Care (DOC) confirmed that the incident was not reported to the Director, that the staff member was not placed off work pending an investigation, no documentation of an investigation into the incident was available for review, including the “Resident Rights, Care and Services – Administration Investigation Checklist” , and there was no documented assessment or interview of the resident in relation to the identified concerns or of the staff member involved.

The home did not follow their written policy that promoted zero tolerance of abuse and neglect of residents in relation to allegations of abuse by a staff member. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #3: 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 failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The following residents had falls, which were reported to the Director; they had the appropriate falls interventions implemented pre and post-fall; however the staff did not ensure that the interventions and the residents' responses to the interventions were documented.

A) Resident #138 had a fall in July, 2016 and was injured. The resident was assessed after the fall as being at high risk. PSWs #331, #332 and RPN #325 were interviewed and they confirmed following the resident's return from the hospital that there were specific falls interventions implemented; however they were not documented on the written plan of care. When reviewing the resident's clinical record there was no documentation of the falls prevention interventions for resident #138 for the months of June and July 2016 in the Point of Care (POC) notes by the PSWs.

B) Resident #139 had a fall in November, 2015 and was injured. The resident was high risk for falls. PSWs #331, #332 and RPN #325 were interviewed and they confirmed that when the resident returned from the hospital that there were specific falls interventions implemented; however they were not documented on the written plan of care. The resident's clinical record was reviewed from October to November, 2015 and there was no documentation related to the resident's response to the interventions for falls prevention and safety checks. In addition, when the resident returned from the hospital, the falls prevention interventions were inconsistently documented up to the end of December, 2015.

C) Resident #140 had a fall in July, 2016 and was injured. The resident was assessed as high risk for falls. PSWs #331, #332 and RPN #325 were interviewed and they confirmed that when the resident returned from the hospital the specific falls prevention interventions were implemented; however they were not documented on the written plan of care. The resident's clinical record was reviewed from June to August, 2016 and there was inconsistent documentation related to the resident's response to the falls prevention interventions.

PSWs #331 and #332 confirmed during the interview that they were expected to document the residents' interventions and responses to these interventions in the POC, and were unsure as to why the documentation was not done.

D) Resident #141 was admitted in November, 2015. The resident was deemed as high risk for falls as a new admission, until the home completed the falls risk assessment on the following day. After the falls assessment was completed, the resident subsequently had two falls within three hours of each other. The written plan of care on admission identified the resident's specific falls prevention intervention. The resident's clinical record was reviewed from November to December, 2015, and there was no documentation related to the specific falls prevention intervention. PSW #312 and registered staff #316 and #325 were interviewed and identified that resident #141 had specific falls prevention interventions implemented, and usually they had the resident positioned in order to monitor them; however they confirmed that the specific falls interventions was not documented in POC.

The home's "Falls Prevention and Management" policy, Version: 3 and revised May 27, 2016 was reviewed and directed staff to document the falls prevention interventions and the residents' responses to the interventions. The Restorative Care Coordinator (RCC) was interviewed regarding resident #138, #139, #140 and #141, and they confirmed the

falls interventions for each of the residents'. The DOC was also interviewed and confirmed that the PSWs were expected to document the hourly safety checks for the residents, and the residents responses to the falls prevention interventions in their POC notes, and as required by the home’s Falls policy. The home failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident’s responses to interventions were documented. [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 that any actions taken with respect to a resident under the nursing and personal care program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in the resident's plan of care only if all of the following were satisfied: 3. The use of the PASD had been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #141 was assessed for bed rails to assist with activities of daily living. The assessment was conducted by the Restorative Care Coordinator (RCC) in December, 2015 and identified the resident required bed rails. The RCC was interviewed and identified that the resident already had bed rails on their bed and based on the assessment, they required the bed rails; therefore the bed rails were left on their bed until the resident was discharged.

The home's policy called "Minimizing of Restraining - Personal Assistive Service Devices (PASDs)", Version 1, and effective April 23, 2015 directed registered staff to obtain a physician or registered nurse in the extended class's (NP) order, and to obtain informed consent from the SDM. The clinical record was reviewed and there was no consent from the substitute decision maker (SDM) and there was no physician or nurse practitioner (NP) order for the Personal Assistance Services Device (PASD). The RCC and the DOC were interviewed and both confirmed that there was no physician or NP order for the PASD and there was no consent signed by the SDM. The DOC confirmed that registered staff were expected to obtain the physician or NP order, and consent from the SDM for the PASD as outlined in the home's policy, and this was not done. The home did not ensure that the legislative requirements were satisfied to include the use of a PASD in resident #141's plan of care. [s. 33. (4) 3.]

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 the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 3. The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations, and 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

A) In May, 2015, resident #063 had a change in condition. The resident was assessed by physiotherapy in May, 2015. In June, 2015, two staff transferred resident #063 without the proper equipment. Resident #063 was interviewed and confirmed that staff did not use the proper equipment. The resident was not injured; however felt rushed during the improper transfer. PSW #318 confirmed the wrong equipment was used to transfer the resident. The Director of Care was interviewed and confirmed that staff did not use the proper equipment as recommended by physiotherapy and as documented in the written plan of care.

B) In August, 2016, resident #020 was transferred incorrectly using the wrong equipment and the equipment was applied incorrectly. The resident sustained an injury as a result of the transfer.

i. The resident was assessed by the Restorative Care Coordinator (RCC) in October, 2014 and March, 2015, which identified they required specific equipment. PSW #333 and #334 confirmed the resident required the specific equipment. PSW #333 and #334, and the Administrator confirmed the specified equipment was not used.

ii. The manufacturer's instructions directed staff how to apply the equipment for transferring. The training materials used for staff education of specific equipment, which was provided by the RCC, directed staff how to apply the equipment correctly. Photographs of the equipment immediately following the fall demonstrated that the equipment was not applied as directed. PSW #333, #334 and registered staff #316 confirmed the equipment was not applied as directed by the manufacturer's instructions, and as outlined in the training provided by the RCC.

The home did not ensure that staff used safe transferring techniques when assisting resident #063 and #020. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to ensure supplies, equipment and devices were readily available to meet the nursing and personal care needs of the resident.

In August, 2016, staff were transferring resident #020 using the wrong equipment and resulting in an injury to the resident. During an interview with PSW #333 and #334, they identified the specified equipment was not available to the staff. The Administrator confirmed the specified equipment was not available to the staff following an immediate search of all home areas. An audit of the equipment was completed by the Restorative Care Coordinator (RCC) in July, 2016, which indicated there was only one piece of equipment available to this unit, but at the time of the resident's transfer the equipment was unavailable. PSW #333, #334 and the RCC confirmed there was one piece of equipment assigned to the unit, that was not available at the time of the resident's transfer. The home did not provide, and make accessible the equipment and supplies for staff to complete the safe lift and transfer of resident #020. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #7: 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 failed to ensure that the nutrition care and dietary services program included the identification of any risks related to nutrition care, dietary services, and hydration with the implementation of interventions to mitigate and manage those risks.

The home's policy, "Resident Rights, Care and Services – Nutrition Care and Hydration

Programs – Hydration", reviewed March, 2015, was not clear on how to identify poor hydration and when to initiate strategies to correct poor hydration. The policy, as it was being applied by staff did not ensure that risks related to hydration were identified and interventions to mitigate and manage those risks were implemented in a timely manner.

The policy directed staff to initiate a "Stop and Watch" program when residents were noted to have low fluid intake (did not specify what level) and to complete an assessment of those residents triggered with a "Stop and Watch" alert on their shift. The policy directed staff to complete a dehydration assessment and document their findings in "dehydration assessment" progress note and to complete a referral to the Registered Dietitian when residents were consuming less than 50% of their assessed fluid goal over a three day period. The policy also directed staff to complete a referral to the Registered Dietitian when the resident was consuming less than their fluid goal over three days.

The Registered Dietitian, Nutrition Manager and Director of Care confirmed that staff were not to refer to the Registered Dietitian for poor hydration or implement the "Stop and Watch" program until residents were identified as consuming less than 50% of their fluid goal over a three day period. The Registered Dietitian confirmed that not all residents at risk for poor hydration would be identified with action taken to address the poor hydration in a timely manner. The Registered Dietitian confirmed that residents could be consuming less than their assessed hydration requirement for a period of 3 months until the next quarterly review prior to strategies being implemented. The Registered Dietitian and Director of Care were unable to provide best practice documentation to support using less than 50% of hydration target as the threshold for assessment and implementation of interventions to correct the poor hydration. The home's policy did not address changes in hydration/fluid consumption until residents reached the high nutrition and hydration risk category and was not preventative with strategies being initiated early to prevent the high risk concerns.

The "Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes" document, written by the Ontario Long Term Care Action Group Dietitians of Canada, June 2007 – revised April 2013, identified that homes should establish procedures for corrective actions, and documentation of same, when fluid intake did not meet residents' requirements or when there was a change in the residents' hydration status.

The presentation at the Dietitians of Canada conference, June, 2016, "Proactive Management of Dehydration in LTC" presented by Twinkle Patel RD, Seasons Care Inc. and Stacey Scaman RD, Seasons Care Inc. identified the need for a proactive versus a

reactive approach to hydration in Long Term Care Homes.

The home’s current hydration policy was not clear in relation to when staff were to intervene. The home’s implementation of the program using their policy was not based on evidence based practices and did not ensure that action was taken in a timely manner when risks related to hydration were identified. [s. 68. (2) (b)]

2. The licensee failed to ensure that a system was in place to monitor and evaluate the food and fluid intake of resident #141 with identified risks related to nutrition and hydration.

Resident #141 was admitted to the home in November, 2015. Documentation did not include any record of food or fluid intake during the resident's first day. A system to monitor the resident's food and fluid intake was not in place that day. The resident's plan of care identified the resident as moderate nutrition risk.

Not all meals and snacks were recorded during the first week of the resident's stay at the home. No food or fluid intake was recorded on a specific date in November, only two meals were recorded on a specific date in December, and one meal was recorded on a subsequent date in December, 2015. A system was not in place that allowed the monitoring and evaluation of the resident's food intake.

The resident was recorded as consuming specific amount of fluids over a three day period in December, 2015, and the resident was sent to hospital on the following day. The resident's poor hydration was not flagged for referral to the Registered Dietitian (RD), and documentation did not support that any strategies had been implemented to address the poor food and fluid intake during the first few days at the home.

A system was not in place to monitor and evaluate the food and fluid intake of resident #141 when there were significant risks related to nutrition and hydration. [s. 68. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the programs include, (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; and (d) 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 #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provided for, (d) preparation of all menu items according to the planned menu.

At the observed afternoon snack service in October, 2016 on a specific unit, PSW #336 confirmed that there was one container of pudding prepared for residents requiring a a special diet menu. The planned snack menu required a special diet cookie and fruit to be prepared and offered to residents. The Nutrition Manager #309 confirmed that several residents required a special diet on the specific unit.

At the observed afternoon snack service in October, 2016, there was one container of what appeared to be berries prepared and available for residents requiring a special diet menu. The planned menu stated that special diet date turnover cookies and fruit were to be prepared and available on the afternoon snack cart that day. The Nutrition Manager #339 confirmed that 15 residents on a specified home area required a special diet menu.

The special diet snack that was prepared and available at both observed snack passes was not consistent with what was required on the planned menu and there were insufficient quantities prepared for the number of residents that required a special diet snack. [s. 72. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs at the observed supper meal in October, 2016.

Dessert was placed on the table for resident #069 while the resident was eating their (hot) entree. The resident had not asked for their dessert to be placed on the table while they were still consuming their entree. PSW #337 stated that the resident wasn't finished their entree so they placed the dessert on the table for the resident for when the resident finished. The Nutrition Manager #338 confirmed that staff were to serve residents course by course and that dessert was not to be placed in-front of residents until they had finished their entrée, unless the resident's plan of care identified all items were to be served together. The Nutrition Manager #338 confirmed that the resident's plan of care did not direct staff to provide their dessert and entrée together. [s. 73. (1) 8.]

2. The licensee failed to ensure that proper techniques were used to assist resident #010 with eating, including safe positioning during meals.

At the observed supper meal in October, 2016, resident #010 was observed slightly reclined with their chin pointing towards the ceiling while the resident was being fed by staff. The resident had a plan of care that directed staff to ensure the resident was in an upright position for safe eating. The resident's head was not positioned to allow for correct positioning and the resident's head was tilted back. PSW #339 stated that was the resident's usual positioning during meals and the resident was not repositioned. The resident was not in a safe position during feeding. [s. 73. (1) 10.]

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 home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs; and that proper techniques are used to assist residents with eating, including safe positioning during meals, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to resident #141 in accordance with the directions for use specified by the prescriber.

Resident #141 was prescribed a medication by the physician. The medication administration record was reviewed for December, 2015 and the medication was signed by the registered staff as administered as ordered; however the resident had been transferred to the hospital several days later and had a change in condition. The resident's SDM was interviewed and confirmed that they observed the resident's change in condition. Registered staff #326 was interviewed and identified that they were on duty at the time the resident was transferred to the hospital and indicated that they were aware that the hospital and the family identified the resident had a change in condition. The DOC confirmed that the registered staff had not followed the directions for the medication. The DOC also confirmed that the registered staff had not administered resident #141's medication in accordance with the physician's order. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber., to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #052 was given an opportunity to participate fully in their care conferences.

During stage one of this Resident Quality Inspection (RQI), resident #052 stated they were not invited to their annual care conference and they were not involved in decisions about their care. The Resident & Family Services Coordinator confirmed that the resident was not invited to attend their annual care conference and stated only the resident's Substitute Decision Maker (SDM) was invited to attend the meeting. The staff member confirmed the resident was not provided an opportunity to provide feedback or review their preferences related to their care, and that the resident could usually tell you their preferences and provide feedback on most days. [s. 27. (1) (b)]

Issued on this 6th day of December, 2016

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

Original report signed by the inspector.