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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 30, 2015;	2015_266527_0019 (A1)	H-003275-15	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF DUFFERIN
151 Centre St SHELBURNE ON L0N 1S4

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

DUFFERIN OAKS
151 CENTRE STREET SHELBURNE ON L0N 1S4

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

KATHLEEN MILLAR (527) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Pblic Copy of the Inspection Report was amended manually to reflect the following changes:

1) s. 8 (1)(b), 2 (E) - The resident number was changed from resident #013 to resident #023.
2) s. 30 (2), 1 (E)(i) - The resident number was changed from resident #018 to resident #022.
3) s. 97 (2) - After further documentation provided by the home to identify that the SDM was notified of the results of the home's investigation into the verbal abuse of resident #043, the LTC Inspector removed the non-compliance, which was identified as 2(B) in the report.

In addition, the Public Copy of Order #001 Report was amended to reflect the change related to the compliance date as a result of consultation with the home. The date was changed from January 15 to January 29, 2016.

Issued on this 30 day of December 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

KATHLEEN MILLAR (527) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): September 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, October 1, 2, 6 and 7, 2015.

During the Resident Quality Inspection (RQI) the following Complaint and Critical Incident Inspections were conducted concurrently:

H-001319-14, H-001570-14, H-001761-14, H-000570-14, H-001978-15, H-002410-15, H-002612-15, H-002650-15, H-003003-15, H-003122-15, H-003236-16, H-003339-15, H-003329-15, and H-003340-15.

In addition, the following Complaint Inspection #2015_266527_0020/H-003137-15 was conducted concurrently with the RQI. The non-compliance's issued are identified in this RQI report, and not in a separate report.

The Complaint and Critical Incidents were inspected for the following: falls, pain management, skin and wound care, continence care and bowel management, hospitalization and change in condition, and nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the administrator, the director of care (DOC), the assistant director of care (ADOC) and continence care lead, the resident assessment instrument-minimum data set (MDS-RAI) coordinator(s) and falls lead, the unit coordinators, the behavioural

support officer (BSO), the food service manager (FSM), the registered dietitian (RD), the physiotherapist (PT), the skin and wound care lead, dietary aides, registered nurses (RNs), registered practical nurses (RPNs), personal support workers / health care attendants (PSWs/HCAs), the housekeeping aides, the building manager, the housekeeping and laundry manager, the social worker, the program and support manager, the family council president, the residents' council president, the residents and their families, and a physician.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

14 WN(s)
12 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (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; 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 :

1. A) The licensee failed to ensure that the plan of care for resident #033 set out clear directions to staff and others who provided direct care to the resident in relation to

supervision required when consuming snacks. The resident had a plan of care that directed staff to assist or supervise with snack cart items and not to leave the resident alone with snack cart items. The plan did not specify whether the supervision was required for both food and fluids or only for food. The resident was observed alone in their room in September 2015, while consuming a beverage that the resident confirmed was from the snack cart. The PSW staff interviewed confirmed the resident was provided beverages unsupervised in their room. The PSW believed the resident only required supervision in their room with food and not beverages; however, registered staff stated that the resident was to be supervised with both food and fluids from the snack cart. Not all staff were clear on whether the resident was to be supervised for both food and fluids from the snack cart.

B) The licensee failed to ensure that there was a written plan of care for resident #034 that set out clear direction to staff and others who provided direct care to the resident related to proper positioning and feeding techniques at meals.

The resident was observed in a reclined position while being fed by staff at the lunch meal in September, 2015. The written plan of care and kardex, that staff were to use to provide care to residents, did not include direction in relation to safe positioning of the resident at meals. The progress notes and a laminated card on the snack cart, completed by the registered dietitian, (RD), directed staff to ensure the resident was sitting upright; however, front line nursing staff did not have access to the progress notes and the snack cart information at meal time. Clear direction related to positioning at meals was not available on the written plan of care that front line nursing staff followed at meal time. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care of resident #022 and #023 collaborated with each other in the assessment of the residents so that their assessments were integrated, consistent with and complemented each other in relation to continence care and bowel management, and skin assessments.

A) The RAI-MDS assessment completed in August, 2015 for resident #022, identified a decline in bowel and bladder function. The "Bowel and Bladder Assessment" tool, completed in August, 2015, was not consistent with the RAI-MDS assessment. The bowel and bladder assessment identified the resident's bowel and bladder continence was stable.

The bowel and bladder assessment completed in August, 2015 identified the resident

required a toileting plan; however, a plan was not identified and was not included in the resident's plan of care. A PSW who routinely cared for the resident was able to identify a pattern and time of day for routine bowel movements and the resident's ability to understand reminders and prompted voiding; however, this information was not included on the bowel and bladder assessment.

Staff did not collaborate with each other in the assessment of resident #022's continence and bowel management resulting in inconsistent assessment of the resident's bowel and bladder continence and toileting needs. (107)

B) The "Dufferin Oaks -- Skin Assessment With Bath", completed by a PSW in July, 2015, identified redness on the resident #023's limb; however, an assessment completed by the nurse practitioner in July, 2015, identified the resident had a new large bruise on the resident's leg. The information related to the resident's skin integrity were not consistent between the two assessments. Registered staff confirmed the assessments were not consistent. [s. 6. (4) (a)]

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

A) The licensee failed to ensure that the care set out in the plan of care for resident #034 was provided to the resident as specified in their plan at the observed meals in September and October, 2015 and the afternoon snack pass in October, 2015.

The resident had a plan of care that required a specific consistency of fluids at meals as part of the Plus Interventions (nutritional interventions for increased calories). The dining room serving list also identified the resident had a dislike of certain foods. The resident was unable to voice their preferences at meals.

i) At the observed meal in September, 2015, the resident received honey consistency thickened water and peach juice. Thickened beverage was not offered or provided to the resident. The resident was also provided pureed vegetables which was not their preference (as per the therapeutic extension menu). The resident was at high nutrition risk.

ii) At the observed meal in October, 2015, resident #034 was provided honey consistency thickened water and white grape juice. The resident was not offered or provided a honey consistency thickened beverage. The PSW assisting the resident stated the resident was not given routinely at lunch. The Dietary Aide confirmed the

resident had not been receiving the thickened beverage at the lunch meal for quite some time due to the resident not receiving dairy products. The Registered Dietitian confirmed the diet list instructed staff to provide honey consistency thickened beverage at meals.

iii) Resident #034 had a plan of care that required a pureed texture menu with honey consistency thickened fluids. At the observed meal in October, 2015, resident #034 received pureed chili which was of a soupy consistency and running over the resident's plate. The Dietary Aide confirmed the texture of the pureed chili was thin and soupy. The Cook stated the pureed food was supposed to be the consistency of pudding (smooth and cohesive). The Cook stated it was the first time that chili had been made and the recipe would be adjusted.

iv) Resident #034 had a plan of care in place that directed staff to ensure honey consistency thickened water was available for the resident at all meals and snacks. A "Swallowing Strategies" list was located on the snack cart and also directed staff to ensure that honey thickened water was provided at snacks. A family member requested thickened water for the resident at the afternoon snack pass in October, 2015; however, the honey consistency thickened water (as per the plan of care and diet list on the snack cart) was not available, nor was water available on the cart for staff to thicken for the resident.

v) Resident #034 required honey consistency thickened beverages at meals and snacks. The resident was offered nectar consistency thickened cranberry juice at the afternoon snack pass in October, 2015. The PSW serving the resident was not aware the resident required honey consistency thickened fluids and confirmed the resident was provided nectar consistency juice. [s. 6. (7)]

4. The licensee failed to ensure that when the resident was reassessed the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident #019 was admitted to the home in 2015. The fall risk assessment upon admission identified the resident was at low to moderate risk for falls. The resident had a fall in March, 2015 and sustained an injury. Post fall, the fall risk committee rounds note in April, 2015 identified that the resident required an intervention. When the registered staff and the falls lead were interviewed they were not able to identify when the written plan of care was reviewed and revised to include this intervention

until they had printed the plans of care with the revision dates. The written plan of care provided by the home was reviewed and identified that this intervention was not initiated until July, 2015. The licensee failed to ensure that the plan of care was revised when the care needs changed for this resident. (561)

B) The licensee failed to ensure that resident #022 was reassessed when their care needs changed in relation to a fall in June, 2015. Documentation in the resident's progress notes, identified the resident had a change in their gait and required increased pain medications after the fall, and would be put in the doctor's binder for the nurse practitioner (NP) to assess in relation to the change. Follow up documentation did not reflect the resident was reassessed by the NP in relation to the gait and medication changes. Registered staff confirmed the resident had not been added to the doctor's book as the progress note stated and therefore, had not been reassessed by the Nurse Practitioner in relation to the changes. (107)

C) The licensee failed to ensure that resident #018 had their plan of care revised when the resident's care needs changed in relation to the level of assistance required for eating at the August 2015 quarterly review. The resident had an increase from independent to requiring supervision in the dining room; however, this was not revised on the resident's plan of care. The RAI-MDS coordinator confirmed that the resident's plan of care was not revised to reflect the requirement for supervision and the plan of care was inconsistent with the coding on the RAI-MDS assessment. During interviews, multiple staff confirmed the resident required supervision during meals. (107)

D) Resident #023 was not reassessed in relation to increasing constipation and did not have their nutrition plan of care revised in relation to identified constipation. The resident had a significant change in condition after a fall in July, 2015, which required an increase in their pain medications. The resident had an increase in medications used to treat constipation during a three month period in 2015. The RD reviewed the resident in September, 2015; however the plan of care was not revised in relation to the increased constipation. The RD noted chronic constipation in September, 2015, and confirmed the nutritional plan of care was not revised in relation to the noted increase and chronic constipation. (107) [s. 6. (10) (b)]

5. The licensee failed to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Resident #017 was considered at high risk for falls according to the written plan of

care since January, 2015, and the fall risk assessment dated July, 2015. The resident had a number of documented falls in July, August and September 2015.

The fall risk committee rounds documented in the progress notes and the written plan of care prior to the falls and post fall. The fall risk committee rounds progress notes identified that the contributing factor for the falls was that resident wandered into other residents' rooms and often tripped over items. Furthermore, numerous falls interventions were implemented. .

The falls lead was interviewed and confirmed that the contributing factors for the resident's falls was wandering into other residents' rooms and tripping over items. The resident falling out of bed was not documented in any of the fall risk committee rounds. The written plan of care between July and September 2015 were not revised to include the new interventions. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance i) To 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 the resident.
ii) To 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.
iii) To ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
iv) To 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, (b) the resident's care needs change or care set out in the plan is no longer necessary.
v) To ensure when a resident is reassessed and the plan of care reviewed and revised, (b) 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, to be implemented voluntarily.

WN #2: 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 failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) was in compliance with and implemented in accordance with applicable requirements under the Act.

A) The home's online "Dietitian Referral" form reflected that only Stage II pressure ulcers would be referred to the RD for assessment, which was not consistent with the legislative requirement, O.Reg. 50(2)(b)(iii) that required residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds to be assessed by a registered dietitian who was a member of the staff of the home.

i) Resident #034 was not assessed by the RD in relation to new skin breakdown identified in the resident's progress notes in August, 2015. The progress notes stated the resident had some slight skin breakdown. The RD confirmed that she was not notified of the skin breakdown and was unaware the resident had skin breakdown at that time.

ii) Resident #033 was not assessed by the RD in relation to new skin breakdown identified in the resident's progress notes August, 2015, and a skin tear identified in the progress notes September, 2015. The RD confirmed she was not notified of the skin breakdown at that time.

The Registered staff interviewed in October, 2015, were unclear when a referral to the RD would be required in relation to skin breakdown and confirmed that they would not refer all areas of skin breakdown to the RD. Not all staff were aware of the legislative requirement to have the RD assess residents in relation to poor skin integrity. [s. 8. (1) (a)]

2. The licensee failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A) In April, 2015 resident #051 and #052 were involved in a physical altercation where resident #052 was pushed to the floor and hit their head causing injury.

The staff responding to the incident initiated the post falls management Head Injury Routine, which directs staff to monitor neurological vital signs every 4 hours for 24 hours. The homes policy called “Falls Prevention and Management Program”, policy #NS 9-010, and last revised November 2014, identified that for post fall management, “the multidisciplinary team will assess the resident for any potential injury associated with the fall, call ambulance if indicated and initiate head injury routine if indicated”. The staff checked the neurological vital signs for resident #052 at 1550 hours, at the

time of the incident, at 1745 hours, and not again until the following day in April, 2015.

The registered staff were interviewed and confirmed that they were responsible for conducting head injury routine checks every 4 hours on a resident who had a fall. The DOC confirmed the expectation of Registered staff was to complete the head injury routine in accordance with the home's policy, and this was not done.

B) The Classic Care Policy and Procedure Manual was reviewed. The policy called "Safe Storage of Medications", number 4.8, and last revised July 2014, identified "medications requiring refrigeration are stored in a refrigerator in the medication room or in a locked box in a refrigerator; the medication refrigerator should:
-have a thermometer to monitor temperature
-be maintained between 2 and 8 degrees Celsius
-not contain vaccines, specimens or food (edible items such as apple sauce, pudding, yogurt, etc. used to facilitate medication administration are not considered food by Classic Care Pharmacy)
-be defrosted, cleaned and maintained as required".

In October, 2015 during an observation of the medication room along with the assistant director of care (ADOC), the LTC Inspector observed that the fridge in one of the medication rooms in the home did not have a thermometer. The fridge stored medications that required to be refrigerated. Furthermore, the fridge was dirty with old food stains. There were also other items in the same fridge, that should not have been there.

The ADOC identified that the home never kept the log temperatures of the fridges that store medications, only the fridge that stored vaccines. The ADOC also identified that there was no policy related to keeping temperatures of these fridges. The DOC was interviewed and confirmed that only medications should have been stored in the fridge and the fridge should have been kept clean. The DOC identified that there was no policy related to keeping the log of temperatures of the fridge that keep medications.

The DOC later identified that Pharmacy had conducted an audit and informed the home about the procedure for maintaining the temperatures of the medication fridges, and the home had not implemented as of yet. (561)

C) The home's policy, "Fluids & Hydration" number 3-200, and last revised October 2012, directed staff to notify registered nursing staff when residents had consumed

less than 1000 mL per day for three consecutive days and to notify the RD of those residents as well.

Resident #018 consumed less than 1000 mL per day over three or more consecutive days during a three month period in 2015.

The RD confirmed she did not receive referrals related to the poor hydration on the identified dates. The RD also identified that the home was having difficulties with documentation and referral of poor hydration prior to July 2015. Staff did not comply with the hydration policy requiring notification of the RD for fluid intake less than 1000 mL per day for three or more consecutive days. According to the food and fluid intake monitoring records, the resident did not meet their hydration requirement on any day over a three week period in September, 2015. (107)

D) The licensee failed to ensure that resident #034 was referred to the RD in relation to swallowing ability after three identified changes in their health status in three identified months in 2015. The home's "Dietitian Referral" form directed staff to refer to the RD for difficulty swallowing as evidenced by certain symptoms, and for a change in health status/new diagnosis. The Registered Dietitian confirmed that multidisciplinary staff were to use and refer to that form for RD referrals.

Documentation in the RAI-MDS Resident Assessment Protocol (RAP) assessment for psychotropic drugs, completed in August, 2015, identified the resident had several changes to their health status in the last 90 days, which was attributed to the resident's swallowing difficulty. The RD noted the June 2015 diagnosis at the August, 2015 quarterly; however, an assessment of the repeated episodes of illness and progress notes related to coughing at meals were not identified. The RD confirmed she had not received referrals related to the three incidents at meals. (107)

E) The home's policy called "Fall Prevention and Management Program", number NS 9-010, and last revised July 2015, directed staff to complete follow up progress notes for three shifts, including vital signs, when there was a fall with no injury, and for six shifts after a fall with an injury. The policy was not complied with by staff for falls sustained by resident #013 in August, 2015. For the fall with injury in August, 2015, the sixth shift follow up note was not completed. For a subsequent fall in August, 2015, only one third of the follow up notes were completed for the fall without injury. The RN was interviewed and confirmed that the documentation did not include all of the required follow up notes as per the home's policy.

F) Resident #019 had a number of falls in April and July 2015. The post fall incident notes were reviewed for all falls and identified that not all of the fall incident notes had vital signs recorded. The fall incident notes did not have vital signs recorded, and there was no note indicating that the resident refused. The home's policy called "Fall Prevention and Management Program", number NS 9-010, and last revised July 2015, directed staff to document vital signs for three shifts if no injury, or for six shifts with an injury. The falls lead and the DOC confirmed that it was an expectation that staff documented the vital signs on the fall incident notes in point click care (PCC) for this resident. (561) [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy called "Abuse Policy", number GN 3-020, and last revised February 2015, directed staff who had reasonable grounds to suspect abuse or improper treatment or care of a resident by anyone were to immediately report the suspicion to the Ministry of Health and Long Term Care (MOHLTC).

A) Resident #047 was treated improperly by a staff member in April, 2014. The improper treatment and care of resident #047 was not reported to the MOHLTC until two days after the incident occurred.

B) Resident #042 was verbally abused by the same staff member in March and September, 2014. The first incident of verbal abuse of resident #042 was not reported to the MOHLTC until fifteen days after the incident occurred. The second incident was not reported to the MOHLTC until two days after the incident.

C) Resident #043 was verbally abused by a staff member in October, 2014. The verbal abuse of resident #043 was not reported to the MOHLTC until three days after the incident occurred.

D) Resident #044 and #045 were verbally abused by a staff member in May, 2015. The verbal abuse of both residents was not reported to the MOHLTC until three days after the incident occurred.

E) Resident #046 was verbally abused by a staff member in August, 2015. The verbal abuse of resident #046 was not reported to the MOHLTC until two days after the incident occurred.

The DOC was interviewed and confirmed that the verbal abuse and improper treatment and care of the residents were not reported to the MOHLTC immediately, and therefore were not in compliance with their policy and the mandatory reporting requirements in the Long Term Care Homes Act (LTCHA). [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 without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #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 failed to ensure that any actions taken with respect to residents #022, #020, and #023, under the Nursing and Personal Support Services program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented.

A) The licensee failed to ensure that documentation reflected that resident #020 was bathed, at a minimum, twice weekly by the method of their choice, unless contraindicated by a medical condition. The plan of care for resident #020 identified the resident preferred a bath twice weekly. The PSW flow sheets reflected that bathing at least twice weekly for five consecutive months in 2015, was not documented.

The resident was observed with hair that appeared unclean during the inspection period. The resident stated they received their baths at least twice weekly. Staff identified that the resident received their baths, but it was not always being documented.

B) The licensee failed to ensure that documentation reflected that resident #022 was bathed, at a minimum, twice weekly by the method of their choice, unless contraindicated by a medical condition. The resident's plan of care identified they preferred a bed bath twice weekly. The PSW flow sheets reflected that bathing at least twice weekly for five consecutive months in 2015, was not documented.

The resident was observed with unclean hair on several days in September, 2015. The resident was not interviewable. Multiple staff were interviewed and identified that the resident received their baths; however, the documentation records were in the tub room and may not have been completed due to the location of the flow sheets. (107)

C) The licensee failed to ensure that documentation reflected that resident #023 was bathed, at a minimum, twice weekly by the method of their choice, unless contraindicated by a medical condition, for three consecutive months in 2015. The resident had a plan of care that required a bath twice weekly. The PSW flow sheets did not reflect the resident received a bath twice weekly.

The resident was not interviewable. Staff were interviewed and identified that the resident received their bath a minimum of twice weekly; however, not all bathing was documented.

D) The licensee failed to ensure that any actions taken with respect to resident #023 under the dietary services and hydration program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

The progress notes in July, 2015, for resident #023, identified a trial of honey consistency thickened fluids. The resident was previously receiving nectar consistency thickened fluids. Documentation did not reflect an assessment of the resident in relation to the change in fluid consistency and did not include the resident's response to the trial fluid consistency. During interview, the food service manager (FSM) and RD could not recall why the resident's fluid consistency was changed, but stated an assessment was completed at that time. Documentation did not include the assessment or any reassessment of the resident.

E) The licensee failed to ensure that actions taken with respect to resident #022 and #023, under the dietary services and hydration program, including assessments, reassessments, interventions and the resident's responses to interventions were

documented.

i) The RD assessed resident #018 in August, 2015, and identified the resident required 2000 millilitre(mL) of fluids daily and noted that the resident was consuming an average of 56% of requirements per day. A water jug intervention had been initiated previously; however, documentation did not reflect an evaluation of the effectiveness of the water jug intervention. During interview, the RD stated she would revise hydration interventions when residents consumed less than 70% of their fluid requirements. Interventions related to hydration were not revised at the August, 2015, nutrition assessment when the resident was not meeting at least 70% of their hydration requirement. The resident continued to have documented poor hydration without revision to their hydration plan of care. Food and fluid intake records reflected the resident was consuming less than 50% of their hydration requirement on 17 days in July and 18 days in August 2015. The Registered Dietitian stated that she had evaluated the effectiveness of the current interventions and felt that a revision to the resident's plan of care was not necessary and felt the resident was receiving more fluids than was being documented. Documentation did not reflect the Registered Dietitian's assessment of resident #022's poor hydration and response to the current interventions in relation to the documented ongoing poor hydration. The RD confirmed the evaluation of the resident's hydration had not been documented.

ii) The RD assessed resident #018 in July, 2015, and identified the resident required 1520 mL of fluids daily and noted that the resident was consuming an average of 66% of the requirements per day. A water jug intervention had been initiated in April 2015. Documentation did not reflect an evaluation of the effectiveness of the water jug intervention. The resident was documented as consuming less than 1000 mL per day over three or more consecutive days (as per the food and fluid intake monitoring records) in May, June, and August, 2015. During interview, the Registered Dietitian stated she would revise hydration interventions when residents consumed less than 70% of their fluid requirements. Interventions related to hydration were not revised at the July, 2015, nutrition assessment when the resident was not meeting at least 70% of their hydration requirement. The resident continued to have poor hydration and had not met their fluid requirement on any day for the first three weeks in September, 2015 without revision to their hydration plan of care. The RD identified that she had evaluated the effectiveness of the water jug interventions and felt that a revision to the resident's plan of care was not necessary as the resident was consuming more fluids per day than was being documented. Documentation did not reflect resident #018's response to the water jug program and rationale for no revisions to the resident's plan of care despite documented ongoing poor hydration.

F) Documentation on the food and fluid intake records reflected that resident #034 consumed less than 1000 mL over three consecutive days on three consecutive months in 2015. The Registered Dietitian confirmed an email referral was received at the beginning of July; however, a referral related to poor hydration was not received for several specific dates in July, 2015. The RD confirmed she did not document an assessment of the poor hydration until August, 2015, when the resident's intake had improved. Documentation did not include a reassessment by the RD, or the resident's response to current interventions in relation to the referrals for poor hydration.

G) Resident #017 had a number of falls in their room; falling out of bed onto the crash mat. The written plan of care from May and July 2015 identified, falls interventions. The resident had a fall in July, 2015 and was found lying face down on the side of the bed with no crash mat. The Fall Risk Committee Rounds had documented in the progress notes, and identified that the resident had two crash mats. The Current written plan of care was reviewed and still identified that the resident had only one crash mat on one side of the bed. The licensee failed to ensure that the written plan of care was revised when the interventions for falls had changed and two crash mats were implemented. [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 a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #022, who was incontinent, had an individualized plan of care to promote and manage bowel and bladder continence and that the plan was implemented. The Bowel and Bladder Assessment tool completed in August, 2015, identified the resident had a decline in their bowel and bladder function and required a toileting plan. Registered staff interviewed were unaware that the resident required a toileting plan and did not identify patterns associated with the resident's continence. The PSW who routinely provided care for the resident was interviewed and identified the resident required a toileting plan with prompted toileting at a certain time or the resident would become incontinent. The individualized toileting plan was not included on the assessment or on the resident's written plan of care, and not all staff were aware the resident required an individualized toileting plan. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for resident #022, who demonstrated responsive behaviours around oral care, that the behavioural triggers were identified, strategies were developed and implemented to respond to those behaviours, and actions were taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions were documented.

Resident #022 was consistently refusing oral care and was not receiving oral care at minimum twice daily. Documentation in the resident's progress notes identified the dental hygienist noted poor oral care and that the resident's gums were moderately inflamed. The resident had refused oral hygiene on numerous times during a three month period in 2015. Staff interviewed identified behaviours related to oral care and that the resident would often not stay in one place long enough to receive oral hygiene. Registered staff interviewed confirmed the resident had not been re-assessed in relation to the ongoing refusal of oral hygiene and confirmed that strategies were not yet developed or action taken to address the ongoing refusal of oral hygiene. Staff interviewed had ideas about strategies that may be effective to encourage the resident to participate in oral hygiene; however, those strategies had not been implemented or included as part of the resident's plan of care. The Behavioural Support Lead confirmed a referral had not been initiated in relation to the resident's ongoing behaviours that resulted in refusals of oral hygiene. [s. 53. (4)]

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, for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The written plan of care for resident #48 indicated the resident had responsive behaviours that manifested as sexually inappropriate behaviours. On the care plan for resident #48 staff were directed to monitor the resident hourly, and allow the resident to wander the unit but only within specified boundaries. On a specific date in December, 2015 resident #48 was located in a female resident's room. Staff interviews confirmed that the resident was not being monitored at the time of the occurrence and was in a living area opposite to their own, and therefore not within the specified boundaries. The BSO champion acknowledged that the expectation was to keep resident #48 away from female residents and to monitor the resident hourly. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were implemented that minimize the risk of altercations and potentially harmful interactions between and among residents.

In April, 2015 resident #051 and resident #052 were involved in a physical altercation where resident #051 pushed resident #052 causing the resident to fall and resulted in an injury. The PSW and RPN did not witness the incident, but responded quickly to assist resident #052; however, they did not provide supervision to resident #051. During this time, resident #051 who was unsupervised and exhibiting aggressive behaviours began to wander the unit and hallway. Resident #051 attempted to physically grab two other residents who were uninjured.

The registered staff and PSWs were interviewed and confirmed that they were expected to re-direct resident #051 when exhibiting behaviours. The ADOC was interviewed and confirmed that resident #051 was expected to be re-directed when exhibiting behaviours. The home's policy called "Responsive Behaviours", number #1-1830, and last revised April 2015, identified that interventions to address risk factors for responsive behaviours included the implementation of 1:1 staffing; this was not implemented until after resident #051 had pushed resident #052, and attempted to grab two more residents while unsupervised. The registered staff, PSWs and BSO confirmed that the procedures for responsive behaviours outlined in the home's policy were not complied with; therefore the risk for potentially harmful interactions between and among residents was not minimized. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, 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 lunch meals September 23 and 25, 2015. The soup course was served concurrently with the entree course at the observed lunch meals. Hot entrees were placed on the table beside the soup and many residents consumed their soup prior to beginning their entrees. Three residents who did not begin consuming their hot entree until after finishing their soup were interviewed by the LTC Inspector and identified that their entrees were not hot enough (#058, #059, #060). The meals had been sitting on the table for up to 20 minutes prior to being consumed. Interview with the FSM confirmed that meals were not served course by course unless specifically requested by residents. Discussion with residents at the Food Committee Meeting dated April 14, 2015, identified that soup would continue to be served with entrees such as sandwiches (cold item) unless otherwise requested. Documentation did not reflect residents had requested hot meals to be served concurrently with their hot soup. [s. 73. (1) 8.]

2. The licensee has failed to ensure that proper techniques, including safe positioning, were used to assist resident #034 with eating meals on specific days in September and October, 2015. Safe positioning and feeding techniques for eating and drinking were identified on a laminated sheet attached to the snack cart and included: making sure the resident was in a proper upright position. The strategies were not included on the resident's written plan. On a specific date in September, 2015 the resident's wheelchair was in a reclined position while staff assisted the resident with eating. Registered staff confirmed the resident was not in a safe position for feeding and the head rest on the resident's wheelchair was not positioned appropriately. On a specific date in October, 2015 the resident was observed leaning to the left and tilted backwards. Staff confirmed the resident's head rest was not in the correct position. [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, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (b) were notified within 12 hours upon the licensee becoming aware of the alleged, suspected or witnessed incident of abuse of the resident.

The home's policy called "Abuse Policy", number GN 3-020, and last revised February 2015", was reviewed and directed staff to notify the resident's substitute decision maker (SDM) within 12 hours of becoming aware of any alleged, suspected or

witnessed incident of abuse or neglect of the resident."

A) Resident #042 was verbally abused by the same staff member on a specific day in March and September, 2014. The resident's SDM was not notified of the two incidents of verbal abuse within 12 hours of the home becoming aware of the alleged abuse.

B) Resident #043 was verbally abused by a staff member on a specific date in October, 2014. The resident's SDM was not notified of the initial abuse within 12 hours of the home becoming aware of the alleged abuse.

C) Resident #044 and #045 were cognitively impaired and were verbally abused by a staff member at the home on a specific date in May, 2015. The residents' substitute decision maker (SDM) was not notified of the initial abuse within 12 hours of the home becoming aware of the alleged abuse.

The DOC was interviewed and confirmed that the home did not notify the residents' SDM within 12 hours of becoming aware of the alleged abuse and improper care and treatment; therefore were not in compliance with their policy and the legislative requirements. [s. 97. (1) (b)]

2. The licensee failed to ensure that the resident's substitute decision-maker (SDM), if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

The home's "Abuse policy", number GN 3-020, and last revised February 2015 was reviewed and directs staff to notify the resident's SDM within 12 hours of the results of the abuse investigation immediately upon the completion of the investigation.

A) Resident #042 was verbally abused by the same staff member on a specific date in March and September, 2014. The clinical record and the home's investigative notes were reviewed and there was no documentation to support that the resident's SDM was notified of the outcome of the home's investigation.

B) Resident #043 was verbally abused by a staff member on a specific date in October, 2014. The home's investigation notes and the clinical record were reviewed and there was no documentation that the SDM was notified of the results of the home's investigation when it was completed.

C) Resident #047 was provided with improper care and treatment by a PSW on a

specific date in April, 2014. The home's investigation notes and the clinical record were reviewed and there was no documentation that the SDM was notified of the results of the home's investigation when it was completed.

The DOC was interviewed and confirmed that the residents' SDM were not notified of the results of the home's investigations immediately upon their completion of the investigations. [s. 97. (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 ensure the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #11: 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 residents in accordance with the directions for use specified by the prescriber.

On a specific date in February, 2015, resident #050 was administered the wrong dose of medication. The Medication Administration Record (MAR) was reviewed and validated the resident received the wrong dose of medication. The registered staff immediately notified the physician and the resident was transferred to the hospital for treatment. The licensee failed to ensure that the medication was administered to resident #050 as prescribed. [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 ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) The tub rooms in four home areas contained communal personal care items.

i) Mulmur: On specific dates in September 2014, three unlabelled nail clippers were found, one unlabelled comb was found, and three unlabelled hair brushes with visible hair in them were found unlabelled.
ii) Mono: On specific dates in September 2014, one unlabelled nail clipper was found and three unlabelled hair brushes with visible hair in them were found unlabelled.
iii) Orangeville: one unlabelled comb was found on a specific date in September, 2015.
iv) Grand Valley: one unlabelled hair brush was found on a specific date in September, 2015.

Staff were interviewed and were unable to identify who the brushes belonged to and identified that all residents were supposed to have their personal care items labelled. The DOC was interviewed and also confirmed that these items should have been labelled with the resident names. (107) (561) [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care for resident #018 was based on identified responsive behaviours and potential behavioural triggers for the resident. The clinical record was reviewed and the progress notes identified the resident had responsive behaviours. The resident's written plan of care did not include the identified triggers. Registered staff and PSWs were interviewed and confirmed that strategies were initiated in July 2015, but discontinued when the strategies were no longer required. The behaviours of the other residents was identified as triggering this resident's responsive behaviours; however, the written plan of care for resident #018 did not include the triggers or the strategies to prevent the responsive behaviours. [s. 26. (3) 5.]

2. The licensee failed to ensure that resident #022's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination. The RAI-MDS assessment completed August, 2015 and the Bowel and Bladder Assessment tool completed August, 2015 identified the resident had a decline in their bowel and bladder function. The resident's written plan of care was not revised to reflect the decline in bowel and bladder function. The Bowel and Bladder Assessment identified the resident required a toileting plan; however, a toileting plan was not included on the assessment or on the resident's plan of care. Registered staff confirmed that the resident's plan of care was not revised based on the interdisciplinary assessments completed August 2015. [s. 26. (3) 8.]

WN #14: 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 hydration program included the development and implementation of policies and procedures related to dysphagia management. The RD confirmed the home did not currently have policies and procedures in place related to dysphagia assessment and management and referral to outside resources when necessary. [s. 68.(2)(a)]

Issued on this 30 day of December 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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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Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KATHLEEN MILLAR (527) - (A1)

Inspection No. / No de l'inspection : 2015_266527_0019 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-003275-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 30, 2015;(A1)

Licensee / Titulaire de permis : CORPORATION OF THE COUNTY OF DUFFERIN
151 Centre St, SHELBURNE, ON, L0N-1S4

LTC Home / Foyer de SLD : DUFFERIN OAKS
151 CENTRE STREET, SHELBURNE, ON, L0N-1S4

Ontario

Ministry of Health and Long-Term Care	Ministère de la Santé et 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Brenda Urbanski

To CORPORATION OF THE COUNTY OF DUFFERIN, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall prepare, submit, and implement a plan that ensures that the care set out in the plan of care related to physician diet order fluid consistency, and resident food and fluid preferences, is provided to residents as specified in the plan.
The plan shall include, but is not limited to:

1. Education for dietary and nursing staff related to the provision of food and fluids according to physician orders and serving lists, and the identification and provision of different fluid consistencies.
2. Review of recipes to ensure the correct consistency of pureed menu items.
3. Quality management activities related to the provision of food and fluids according to physician order and serving lists, and accurate provision of thickened consistency fluids.

The plan shall be submitted by December 18, 2015 to Long Term Care Homes Inspector, Michelle Warrener, using e-mail to: Michelle.Warrener@ontario.ca
The plan shall be implemented by January 29, 2016.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care for resident #034 was provided to the resident as specified in their plan at the observed meals in September and October, 2015 and the afternoon snack pass in October, 2015.

The resident had a plan of care that required a specific consistency of fluids at meals as part of the Plus Interventions (nutritional interventions for increased calories). The dining room serving list also identified the resident had a dislike of certain foods. The resident was unable to voice their preferences at meals.

A) At the observed meal in September, 2015, the resident received honey consistency thickened water and peach juice. Thickened beverage was not offered or provided to the resident. The resident was also provided pureed vegetables which was not their preference (as per the therapeutic extension menu). The resident was at high nutrition risk.

B) At the observed meal in October, 2015, resident #034 was provided honey consistency thickened water and white grape juice. The resident was not offered or provided a honey consistency thickened beverage. The PSW assisting the resident stated the resident was not given routinely at lunch. The Dietary Aide confirmed the resident had not been receiving the thickened beverage at the lunch meal for quite some time due to the resident not receiving dairy products. The Registered Dietitian confirmed the diet list instructed staff to provide honey consistency thickened beverage at meals.

C) Resident #034 had a plan of care that required a pureed texture menu with honey consistency thickened fluids. At the observed meal in October, 2015, resident #034 received pureed chili which was of a soupy consistency and running over the resident's plate. The Dietary Aide confirmed the texture of the pureed chili was thin and soupy. The Cook stated the pureed food was supposed to be the consistency of pudding (smooth and cohesive). The Cook stated it was the first time that chili had been made and the recipe would be adjusted.

D) Resident #034 had a plan of care in place that directed staff to ensure honey consistency thickened water was available for the resident at all meals and snacks. A "Swallowing Strategies" list was located on the snack cart and also directed staff to ensure that honey thickened water was provided at snacks. A family member requested thickened water for the resident at the afternoon snack pass in October, 2015; however, the honey consistency thickened water (as per the plan of care and diet list on the snack cart) was not available, nor was water available on the cart for staff to thicken for the resident.

E) Resident #034 required honey consistency thickened beverages at meals and snacks. The resident was offered nectar consistency thickened cranberry juice at the afternoon snack pass in October, 2015. The PSW serving the resident was not aware the resident required honey consistency thickened fluids and confirmed the resident was provided nectar consistency juice. [s. 6. (7)] (107)

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

Jan 29, 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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 30 day of December 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KATHLEEN MILLAR - (A1)

Service Area Office /
Bureau régional de services : Hamilton