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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 23, 2017	2017_544527_0005	007426-17	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), DARIA TRZOS (561), HEATHER PRESTON (640)

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): April 12, 13, 18, 19, 20 21, 25, 26 and 27, 2017.

This inspection included a follow-up to a Director's Order #001, Log #006987-17, which was issued January 11, 2017, pursuant to section 153 (1)(b) of the Long Term Care Home Act (LTCHA).

The following critical incidents were inspected concurrently with the Resident Quality Inspection (RQI). They included:

Log #033926-16 related to a fall; and
Log #002300-17 related to responsive behaviours.

The following inquiries where also conducted onsite, which included:

Log #001344-17 related to abuse; and
Log #006038-17 related to abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the RAI Coordinator, the Unit Coordinators, the Behavioural Support Ontario Registered Practical Nurse (BSO-RPN), Environmental Services Manager (ESM), Maintenance Manager, Registered Dietitian (RD) Housekeeping Aides, Dietary Aides, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs), family members, and residents.

During the course of the inspection, the inspector(s): toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, policies and procedures and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 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. (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 the care set out in the plan of care was provided to the resident as specified in the plan.

The current written plan of care for resident #026 was reviewed and indicated nail care was to be done by registered staff.
In an interview, PSWs #146 and #147 who provided direct care to the resident stated that resident's nails were being trimmed by PSWs on bath days.
The Point of Care (POC) documentation was reviewed and indicated that the PSWs signed for the nail care on bath days in April 2017.
The home's policy titled "Foot & Nail Care Routine", policy number 1-1952, and last revised July 2015, directed PSWs to not cut the nails of residents with specific medical conditions.
RN #148 was interviewed and confirmed that the resident had a specific medical condition and their nail care should have been done by registered staff and not by PSWs as indicated in the written plan of care.
The home failed to ensure that the care set out in the plan of care was provided to resident #026 as specified in the plan.

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 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 and that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure a resident that exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) During Stage 1 of the Resident Quality Inspection (RQI), resident #012 was observed on five specific dates in April 2017, and had altered skin integrity. Towards the end of April 2017, there were new areas of altered skin integrity observed by LTCH Inspector #640.
Review of the written plan of care identified the resident was at risk of altered skin integrity.
PSWs #135 and #140 were interviewed and indicated that the resident often sustained areas of altered skin integrity when they had falls.
Review of the "Skin and Wound Care Program", policy number 1-1950, and last revised June 2016, directed staff to complete a skin assessment, the home's clinically appropriate assessment instrument, for residents identified as being at risk of altered skin integrity and when altered skin integrity was observed.
Interview with the wound care coordinator confirmed a clinically appropriate skin assessment instrument was expected to be completed for residents at risk of altered skin integrity and with observation of altered skin integrity. The wound care coordinator

confirmed that weekly skin assessments were expected to be completed for altered skin integrity until it was resolved.
Review of the clinical record revealed no clinically appropriate skin assessment instrument was completed for the altered skin integrity. Also, the progress notes and assessments did not include monitoring of the altered skin integrity.
RPNs #100, #112 and #130 confirmed the new areas of altered skin integrity had not been assessed using a clinically appropriate assessment instrument, nor was the altered skin integrity being assessed weekly.
During interview with the DOC, they confirmed that a clinically appropriate assessment instrument was expected to be completed for resident #012's altered skin integrity and the assessments were not completed. (640)

B) Clinical record review for resident #011 was completed in April 2017. A progress note on a specific date in December 2016, indicated that resident #011 had altered skin integrity and a cream and dressing was applied. The skin assessment using a clinically appropriate instrument specifically designed for skin and wound could not be found in resident's clinical records. Further review of the clinical records revealed that the resident was admitted to the hospital in December 2016, and returned to the home several days later. Upon re-admission the skin assessment that was completed, indicated that the resident had altered skin integrity that was present prior to their admission to hospital.
RN #110 was interviewed and indicated that it was an expectation that registered staff complete a skin assessment using a clinically appropriate tool when the resident had altered skin integrity, provide appropriate treatment, monitor, refer the resident to the wound care nurse, registered dietitian and update the care plan. The RN confirmed that this was not completed for resident #011 in December 2016.
The home's policy titled "Skin and Wound Program", number 1-1950, and last revised on June 2016, indicated that upon discovery of a wound the registered staff were to initiate a baseline assessment utilizing the wound assessment tool.
The DOC was interviewed and confirmed that it was an expectation that registered staff complete a wound assessment for resident #011 when they had alteration in skin integrity in December 2016.

The home did not ensure that residents #011 and #012 received skin assessments using a clinically appropriate assessment tool for altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home.

Review of the resident #011's clinical records revealed that the resident was admitted to the hospital in December 2016, and returned two days later. Upon re-admission the skin assessment indicated that the resident had altered skin integrity that was present prior to their admission to the hospital. The progress notes were reviewed and indicated that the resident had altered skin integrity prior to going to the hospital.
RN #110 was interviewed and indicated that it was an expectation that registered staff refer the resident to the Registered Dietitian (RD) when there was skin alteration such as pressure ulcers and skin tears. The clinical records were reviewed and the referral to the RD could not be found.
The RD was interviewed and confirmed that it was an expectation that staff refer residents to them upon discovery of a skin alteration and confirmed that they did not receive a referral for this resident in December 2016.
The home did not ensure that resident #011 was assessed by the registered dietitian when they had altered skin integrity in December 2016, prior to being transferred to the hospital.

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition and hydration program included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

During Stage 1 of the Resident Quality Inspection (RQI), resident #018 triggered for weight loss.
On a specific date in January 2017, resident #018 was transferred to hospital and several days later the resident was re-admitted to the home.
Review of the clinical record revealed the resident lost weight between September 2016 and March 2017. Review of the Point of Care (POC) documentation for meal consumption during the month of February 2017, revealed that 66% of meal times the resident consumed below 50 per cent (%) of their meals. Review of the snack consumption for the month of February 2017, revealed that 73% of all offered snacks were consumed below 25% of the time and 45% of snacks were not consumed at all.
The home's "Fluid Monitoring and Hydration Risk" policy, number 3-210, and last revised January 2016, addressed the monitoring of fluid intake and did not include monitoring of food intake.
During an interview with the RD they confirmed that the home did not have a policy or process for monitoring food intake, just fluid intake. During interview with the DOC, they confirmed the evening PSW totaled the fluid intake for all residents but does not monitor or total food intake for any resident. The DOC confirmed the home does not have a policy or process to monitor food intake for any resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the programs include, (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 #4: 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 the Administering and Documenting Controlled Substances policy was complied with.

The section 114 (3) of the Long Term Care Homes Act, 2007 Regulations indicates that the Medication Management System written policies and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and if, there were none, in accordance with prevailing practices.
The policy titled "Administering and Documenting Controlled Substances", number 4.3, last revised December 2016, indicated that the quantity of every controlled substance was verified for accuracy at the change of each shift with two registered staff members; shift counts were not completed in advance by the outgoing nurse prior to the arrival of the incoming nurse.
The home's end of shift controlled narcotic count sheets on four specific units were reviewed in April 2017, and revealed that there were signatures missing on multiple days.

The ADOC was interviewed and confirmed that the controlled narcotic count sheets should have been signed with two registered staff at all shift changes and confirmed that the staff did not comply with their policy.

WN #5: 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 there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and the policy was complied with.

On a specific date in January 2017, staff #126 had witnessed PSW #124 being disrespectful, rude and used a swear word at resident #045. The home became aware of the alleged abuse the following day in January 2017 and immediately reported to the Ministry of Health and Long Term Care (MOHLTC).
The home's "Abuse Policy", number GN-3-020, and last revised January 2017, directed staff that if abuse occurred they were to immediately report it to their Supervisor/Manager.
Staff #126 was interviewed and confirmed that they did not immediately report the alleged staff to resident verbal or emotional abuse until the following day after the incident occurred. The staff member indicated that they were trained to report any alleged, suspected or actual abuse immediately and that they knew they had not followed their abuse policy.
Interview with Manager #116 confirmed that staff #126 failed to immediately report the witnessed alleged staff to resident abuse to the registered staff, unit coordinator or a manager on the date the incident occurred. Manager #116 also confirmed that staff #116 did not comply with the home's Abuse policy.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

A) Resident #017 was observed during Stage 1 of the Resident Quality Inspection (RQI) in April 2017 as being unshaven. The resident was subsequently observed on three specific dates and remained unshaven.
The resident required extensive assistance of one staff with constant supervision for personal hygiene and grooming. The resident's bath schedule and POC documentation were reviewed and the resident had their bath during the time of the observations and they remained unshaven.
Interview with RPN #100 identified that shaving of residents should be care planned as an intervention and the assistance required. The RPN also indicated that shaving for this resident should be in the point of care (POC) notes as a task for the PSWs to document when it was completed.
Interview with PSWs #101, #107 and #120 confirmed that certain residents would be shaved, if needed, on their bath days, that it would be identified in their written plan of care, and they would document in POC when the resident was shaved.
Interview with the RN #121, #127, and the RAI Coordinator confirmed that certain residents would be shaved on their bath day and whenever necessary, as well, if the resident did not have a razor that the home would provide disposable straight razors. They also confirmed that this task would be documented in the written plan of care and the PSWs were expected to document the completed task in POC.
The resident's clinical record was reviewed for January, February, March and April 2017, and there was no task for shaving for this resident and there was no documentation in POC that the resident had been shaved.
Resident #017 did not receive individualized personal care, which included hygiene care and grooming, on a daily basis. (527)

B) Resident #003 was observed during Stage 1 of the RQI on a specific date in April 2017 as being unshaven. The resident was also observed on other dates in April 2017, and remained unshaven.
The resident was interviewed; however due to their cognitive impairment they could not voice their preference for shaving.
The Minimum Data Set (MDS) quarterly assessment dated March 2017, indicated that resident #003 required limited assistance with one person physical assist for personal hygiene. The current written plan of care reviewed in April 2017, identified that the

resident required supervision, reminders and verbal cues and minimal assist for personal hygiene.
In an interview, PSW #119 who provided direct care to the resident stated that residents were being shaved on an as needed basis, usually on daily basis; however some were able to shave by themselves. The care plan should identify this. Shaving for certain residents was being done on a as needed basis or upon request. If a certain resident preferred not to be shaved this should also be care planned. PSWs document the task in POC. PSW #119 checked the POC and indicated that the task was not added to the POC for this resident. PSW #119 indicated that resident #003 was shaved on a specific morning in April 2017, and not documented in POC as being done.
The RAI Coordinator was interviewed and stated that the PSWs document if they had shaved a resident on POC. Shaving was a task added to the POC; however if a resident was able to shave by themselves this would be care planned and the task would not have been added to the POC. The care plan should also identify if residents prefer not to be shaved.
This resident's clinical record was reviewed and indicated that between the months of January to April 2017, there was no documentation found to indicate whether the resident was shaved. The written plan of care was reviewed and did not address shaving as a task on a specific date in April 2017.

C) Resident #018 was observed during Stage 1 of the Resident Quality Inspection (RQI) on a specific date in April 2017, as being unshaven. The resident was subsequently observed on three specific dates in April 2017, and remained unshaven.
The resident required extensive assistance of two staff for personal hygiene and grooming. According to the bath list on the unit, the resident had a bath on specific dates before and during the observations conducted by LTCH Inspector #561 and the resident remained unshaven.
Interview with RPN #100 identified that shaving of certain residents should be care planned as an intervention and the assistance required. The RPN also indicated that shaving for this resident should be in the point of care (POC) notes as a task for the PSWs to document that it was completed.
Interview with PSWs #101, # 107 and #120 confirmed that certain residents would be shaved, if needed, on their bath days, that it would be identified in their written plan of care, and they would document in POC when the resident was shaved.
Interview with the RN #121, #127, and the RAI Coordinator confirmed that certain residents would be shaved on their bath day and whenever necessary, as well, if the resident did not have a razor that the home would provide disposable straight razors, they confirmed that this task would be documented in the written plan of care and the

PSWs were expected to document the completed task in POC.
The resident's clinical record was reviewed and there was no task for shaving of this resident and there was no documentation in POC that the resident had been shaved.
Resident #018 did not receive individualized personal care, which included hygiene care and grooming, on a daily basis. (640)

D) Resident #025 was observed during Stage 1 of the Resident Quality Inspection (RQI) on a specific date in April 2017, as being unshaven. The resident was subsequently observed on several other dates in April 2017, and remained unshaven.
The resident required extensive assistance for personal hygiene and grooming.
The written plan of care directed staff to shave the resident on bath days. The resident's bath days were identified from the bath schedule for April 2017. The task of shaving was included in Point of Care (POC) and was documented for four of the six dates in April 2017.
Interview with PSWs #101, # 107 and #120 confirmed that certain residents would be shaved, if needed, on their bath days and as needed at other times. Interview with the RN #121, #127, and the RAI Coordinator confirmed that certain residents would be shaved on their bath day and whenever necessary.
Resident #025 did not receive individualized personal care, which included hygiene care and grooming, on a daily basis.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, including the cleaning of dentures.

Resident #026 had a plan of care indicating that they had their own teeth and a denture.
PSWs #147 and #146 were interviewed and both stated that the resident had their own teeth and resident was able to brush them by themselves when cued and encouraged; the staff never took out the resident's dentures to clean them.
RPN #150 was interviewed and was not aware if the resident had dentures or their own teeth; however, once they reviewed the written plan of care, they stated that the resident had a denture but was not sure if it was removable.
The ADOC was interviewed and indicated that the resident's denture was removable and should have been soaked at night and cleaned in the morning.
The home did not ensure that resident #026's denture was being removed and soaked at night as per the plan of care. (561)

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that an individualized menu was developed for each resident whose needs could not be met through the home's menu cycle.

During Stage 1 of the Resident Quality Inspection (RQI), resident #018 triggered for weight loss.
On a specific date in January 2017, resident #018 was transferred to hospital and a couple of days later the resident was re-admitted to the home.
Review of Point of Care (POC) documentation for meal consumption during the month of February 2017, revealed that 90% of the meals the resident consumed was below 50%.

The written plan of care directed staff to assist the resident for the task of eating. If the resident refused the meal that was offered, staff was to offer a sandwich.
On three specific dates in April 2017, the LTCH Inspector #640 observed the resident to be disinterested in their lunch meal and wasn't offered the recommended sandwich as per the plan of care.

Interview of PSW #120 and #122 revealed that if resident #018 didn't like the first meal choice, staff offered the second choice. If they didn't like that PSW #122 gave them another alternative. The PSW identified the written plan of care directed them to give a sandwich but this did not occur. Otherwise resident #018 was given something from the snack cart.
Interview with RPN #123 who stated that resident #018 was independent and required encouragement to eat. RPN #123 was not aware the plan of care identified a sandwich as a preference. Interview of RPN #113 also agreed that the resident ate poorly most of the time. RPN #113 told the LTCH Inspector there were neither formal interventions nor anything specific on the plan of care for this resident's meal preferences.
Interview with PSW #120 who stated when the resident refused both meal choices, resident #018 was given something from the snack cart. PSW #120 indicated the resident was getting a sandwich on the evening snack cart but this had not been the case for a couple of months.
Interview with Dietary Aide #115 regarding evening snacks for resident #018 identified the Dietary Aide recalled a type of sandwich had previously been on the evening snack cart for this resident. The LTCH Inspector and the Dietary Aid reviewed the prepared and labelled snacks for resident #018's home area. There were no labelled snacks found for this resident. The printed evening snack labels for the following day were reviewed and did not include any label for a snack for resident #018.
During an interview with the Registered Dietitian (RD), the RD confirmed that resident #018 required an individualized menu and did not have one in place.
During an interview, the DOC confirmed that resident #018's needs had not been met through the home's menu cycle and an individualized menu had not been developed.

Issued on this 26th day of May, 2017

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

Original report signed by the inspector.