Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'Inspection
February 28, March 1, 2, 3, 4, 8, 9, 10, 11, 14, 15, 2011	2011-165-2777-03MAR142135	Resident Quality Inspection H-000803-11

Licensee/Titulaire
Eden House Care Facility Inc.
RR#2, Guelph, Ontario
N1H6H8
519-856-1274

Long-Term Care Home/Foyer de soins de longue durée
Eden House Nursing Home
5016 Wellington County road 29
RR#2, Guelph, Ontario
N1H 6H8
519-856-9171

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

Yvonne Walton, Sharlee McNally, Michelle Warrener and Tammy Szymanowski

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspectors spoke with: the administrator, director of care, acting director of care, office manager, registered staff, registered dietitian, RAI MDS co-coordinator, personal care workers, food service manager, dietary staff, recreation staff, residents and family members.

During the course of the inspection, the inspectors: reviewed clinical health records, reviewed policy and procedures, observed meal service, observed environment, observed resident care, observed activities and reviewed meeting minutes.

The following Inspection Protocols were used during this inspection: Admission process, dining observation, family council interview, infection prevention and control, medication, quality improvement, resident charges, resident council interview, responsive behaviours, minimizing restraints, personal support services, skin and wound, continence care and bowel management, accommodation services-maintenance, housekeeping and laundry, recreational and social activities, falls prevention, dignity, choice and privacy, nutrition and hydration, pain, and safe and secure home.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

25 WN
11 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, s.15(2)(a)(c) Every licensee of a long term care home shall ensure that, (a) the home, furnishings and equipment are kept clean and sanitary; (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Findings:

1. Two resident wheelchairs and walkers were soiled.
2. An identified wheelchair had cracked vinyl arm rests.
3. Throughout the home several easy chairs had worn arms and legs and the loveseat by the nursing station has a vinyl seat starting to crack.

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WN #2: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, s.3(1)8 Every licensee of a long term care home shall ensure that the following rights of residents are fully respected and promoted: (8)Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:

1. One resident was being showered in the Wellington wing tub room, while another resident was being bathed in the tub, at the same time. There was no privacy curtain around the tub, to provide privacy to residents while bathing.
2. Resident's interviewed stated they are bathed while other residents are in the tub room.
3. Personal care staff interviewed stated they do not consistently bathe only one resident at a time in the tub room.

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WN #3: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, s.30 (1)3 Every licensee of a long term care home shall ensure that no resident of the home is (3) is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Findings:

1. The restraint plan of care for an identified resident identifies bed rails are used when the resident is in bed for safety in relation to the risk for falls. The plan of care does not include an order by the physician or the registered nurse in the extended class for the use of bed rails and does not include consent by the resident's substitute decision maker in relation to the use of bed rails as a restraint.
2. Registered staff interviewed stated that orders and consents are not obtained for the use of bed rails as restraints for residents.

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WN #4: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, s. 6(1)(c) Every licensee of a long term care home shall 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.

Findings:

1. The plan of care for an identified resident is conflicting and does not provide clear direction to staff providing care. The nutrition risk plan of care indicates the resident requires placement at a table where extensive encouragement can be provided, however, the eating plan of care indicates the resident requires minimal assistance. During the lunch meal, the resident was sitting at a table without staff assistance. The resident left the table without staff re-direction and the resident did not consume a lunch meal.
2. After sustaining a fall, recommendations by the falls committee for an identified resident indicated specific interventions. The resident is identified as being a high risk of falls however; the plan of care does not include clear direction for staff providing care around this strategy and a care staff member interviewed provided conflicting strategies and was unable to identify current interventions related to toileting and the prevention of falls.

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WN #5: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, s. 6(10)(b) 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, (b) the resident's care needs change or care set out in the plan is no longer necessary.

Findings:

The plan of care was not revised when an identified resident's care needs changed (decline in condition, change in behaviour) and when the care set out in the plan was no longer necessary:

1. The resident's plan of care states the resident climbs out of bed 3-4 times monthly, however, staff interviewed stated the resident has not been able to climb out of bed for over one year.
2. The plan of care identifies the need for specific interventions for pain relief however; staff interviewed stated the resident no longer receives this intervention.
3. The plan of care identifies the use of specific devices during meals; however, staff interviewed stated this intervention was no longer required and was not used during lunch meals observed.
4. The resident was using a specialized wheelchair throughout the inspection; however, the plan of care has not been revised to include the use of the specialized wheelchair.
5. The resident had a tabletop at meals; however, the plan of care has not been revised to include the use of the table top.

6. The plan of care for an identified resident was not revised when there was a change in the resident's condition and decline in health status:
7. The resident's nutritional supplement was changed however; the plan of care was not revised.
8. The resident's diet texture was changed however; the plan was not revised to reflect the change.
9. Recreational plan of care was not revised related to the change in the resident's ability to walk around the home.
10. The resident was changed from low to high risk for falling on the RAI-MDS (Resident assessment instrument and minimum data set) assessment tool. The plan of care related to falls was not revised to reflect the increased risk for falling.
11. The plan of care for an identified resident was not revised to reflect the increase in responsive behaviour. The assessment protocol completed in January 2011 identifies that the resident is physically and verbally abusive towards staff however; the resident's plan of care has not been revised to include strategies to manage the behaviour. The resident's health record indicates the resident had two episodes of responsive behaviours towards staff resulting in injury to the staff, in the past two months.
12. The plan of care for an identified resident was not based on an interdisciplinary assessment related to the resident's change in pain levels post fall. The order for pain medication was changed by the Physician however there was no evidence of reassessment related to the resident's increase in pain.
13. An assessment of an identified resident's hydration status was completed by the dietitian with assessed fluid requirements. Documentation in the resident's health record indicates current fluid consumption is between 950-1450ml/day less than the assessed requirements for this resident. The resident has not been reassessed with a plan of care developed to address the change in hydration status.

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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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, 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.

Findings:

Residents participating in the Restorative dining program were not offered fluids consistent with their current plan of care:

1. Several identified resident's have a plan of care to receive 175ml coffee/tea, 125ml water, 175ml milk three times daily at meals. The residents were not offered coffee/tea or water.
2. Two identified resident's have a plan of care to receive 175ml coffee/tea, and 175ml milk three times daily at meals. The residents were not offered tea/coffee.
3. One identified resident did not receive a straw for fluids during the lunch meal as indicated in the resident's care plan for restorative feeding and the resident was spoon fed thickened fluids.
4. One identified resident was only provided 175ml of milk despite interventions in the resident's plan to offer beverages frequently as the resident cannot express thirst.
5. An identified resident has a plan of care to receive 175ml coffee/tea, and 175ml milk in a cup with a lid at meals. At the lunch meal the resident was provided one cup with a lid containing 175ml water. The

plan of care states the resident likes milk at all meals, however, this was not provided.

6. The plan of care for an identified resident states occupational therapy assessed the resident and staff are to provide a special device for eating. The special device was not provided during the lunch meal service. Staff interviewed stated they do not use the device at meals.
7. An identified resident's plan of care includes the intervention of providing food they like if they refuse a meal. The resident was provided a food they like however the main entrée was not offered to the resident first. The resident was only offered soup which was refused.
8. An identified resident's plan of care for toileting indicates the resident requires two staff with constant supervision and extensive physical assist for safety however; constant supervision was not always provided. The resident was on the toilet with no staff present, leaving the resident unattended for fifteen minutes. The resident was already on the toilet with no staff present, leaving the resident unattended for at least thirty-seven minutes without constant supervision as indicated in the plan of care. Staff interviewed indicated the resident does not require constant supervision.
9. Tea, water, sandwich, salad and pudding was placed in front of the resident during the lunch meal, however, the resident's plan of care states to place only one item in front of a resident at a time and to provide half of the entrée at a time so the plate does not look too full. The plan of care directs staff to serve the second half of entrée once the resident has completed the first half.
10. An identified resident was observed on two occasions, once after a bath was provided and once after morning care was provided with black debris under several fingernails. The resident's plan of care identifies the resident is to have nail care provided when bathed. Staff stated that the resident receives nail care on bath days however; the resident's records for March 2011 indicate the resident only received nail care on one of the bath days.

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WN #7: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s.78(2)(a),(b),(c),(d),(e),(q)

The package of information shall include, at a minimum, (a) the Residents' Bill of Rights; (b) the long term care home's mission statement; (c) the long term care home's policy to promote zero tolerance of abuse and neglect of residents; (d) an explanation of the duty under section 24 to make mandatory reports; (e) the long term care home's procedure for initiating complaints to the licensee; (q) explanation of the protections afforded by section 26.

Findings:

1. A new Resident's Bill of Rights was introduced through the Long Term Care Homes Act on July 1, 2010. Review of records for three residents admitted to the home identified that two residents did not have a copy of the current Bill of Rights provided with their admission contract.
2. The admission package currently being provided does not include the home's mission statement. The home has developed a new admission package which incorporates the mission statement but as of March 8, 2011 has not been implemented.
3. The admission package currently being provided to newly admitted residents and/or their substitute decision maker does not include the home's policy to promote zero tolerance of abuse and neglect to residents.
4. The admission package currently being provided does not include an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm of a resident.
5. The admission package currently being provided does not include the home's procedure for initiating complaints to the licensee.
6. The admission package currently being provided does not include an explanation of "whistle-blowing" protections related to retaliation.

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WN #8: The Licensee has failed to comply with O.Reg 79/10 s.110(7)6
Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. all assessment, reassessment and monitoring, including the resident's response.

Findings:

1. Documentation does not reflect that two identified residents are monitored while physically restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by the registered nursing staff. Documentation of monitoring is completed by the personal care staff every two hours.
2. An identified resident's condition has not been consistently reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class or a member of the registered staff at least every eight hours. Registered nursing staff stated they sign the restraint flow sheet every eight hours, however; documentation on the restraint flow sheet for January 2011 has twenty-seven missed signatures and February 2011 has five missed signatures.
3. An identified resident's condition has not been consistently reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class or a member of the registered staff at least every eight hours. Registered nursing staff stated they sign the restraint flow sheet every eight hours, however; documentation on the restraint flow sheet for March 1 to March 13, 2011 had eleven missing signatures.

Inspector ID #:	107 and 165

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 every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: all assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10 s.134(a)
Every licensee of a long term care home shall ensure that, (a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Findings:

1. An identified resident complained of a headache at the time of a fall, and medication was administered. Medication was administered again on the same day for the resident's complaint of a headache. Progress notes and Medication Administration Records (MARs) do not identify the effectiveness of either medication administration.
2. Medication was administered for the resident's complaint of pain but the progress notes and MARs do not identify the effectiveness of the medication administration.

Inspector ID #:	141

WN #10: The Licensee has failed to comply with O.Reg 79/10 s.137(2)(5)
Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 36 of the Act is documented, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented (5)

discussions with the resident or, where the resident is incapable, the resident's substitute decision maker, following the administration of the drug to explain the reasons for the use of the drug.

Findings:

1. An identified resident received medication, in response to behaviours. There is no documentation in the clinical notes that the substitute decision maker was notified (resident is unable to make care decisions for them self). Interview with registered staff and the Director of Care verified that the family was not notified.

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WN #11: The Licensee has failed to comply with O.Reg 79/10 s.17(1)(a)
Every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

Findings:

1. Seven of eighteen call bells in resident rooms were inaccessible on March 8, 2011. Call bell cords were dangling on the floor behind bedside tables and beds and could not be easily seen, accessed and used by residents, staff and visitors throughout the home.
2. The call bell beside the tub in the Wellington Wing tub room and a resident's room located in Halton wing could not be activated by residents or staff due to poor state of repair. On March 1 and 8th, 2011 the light did not turn on in the hall and it was not audible when pulled by the inspector.

Inspector ID #:	169 and 107

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times where required, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10 s.229(4)
The licensee shall ensure that all staff participate in the implementation of the program (Infection Prevention and Control).

Findings:

Staff do not consistently participate in the implementation of the infection prevention and control program.

1. In the Eden wing tub room March 1 and 2, 2011, a clean linen cart with clean linens was placed next to an uncovered dirty linen hamper that had soiled linen in the bag.
2. On March 10, 2011 at 1520 hours a clean linen cart with linens stored on it was in the Eden Wing hallway and touching a dirty linen hamper that was uncovered and had soiled linen in the bag.
3. Several resident ensuite washrooms throughout the home had unwrapped toilet paper rolls placed on the backs of toilets.
4. Hand hygiene by nursing staff was not completed between handling soiled dishes then serving food to the residents and providing care, during the lunch meals February 28 and March 8, 2011.
5. Four combs and a hairbrush were found unlabelled in the Wellington wing tub room. Two combs were not clean and the hairbrush was filled with hair, one pink hairbrush filled with hair was found unlabelled in the Halton tub room.
6. Staff in Halton wing were handling soiled linens and then handling clean linens without washing their hand in between.

Inspector ID #:	141, 169 and 165

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(3)5.
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.

Findings:

1. There is no evidence in an identified resident's health record of an interdisciplinary assessment of responsive behaviours including any potential behavioural triggers. Staff interviewed identified several potential triggers. The plan of care does not identify these behavioural triggers with strategies to manage the behaviours.

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WN #14: The Licensee has failed to comply with O.Reg 79/10 s. 50(2)(b)(iii)
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, (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.

Findings:

1. An identified resident currently has staged wounds. There is no evidence that an assessment was completed by the home's dietitian for the open wounds. It was confirmed with the acting director of care that no assessment had been completed for the current wounds. The resident's nutritional plan of care did not identify the current wounds.

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WN #15: The Licensee has failed to comply with O.Reg 79/10 s. 67(1)(a)
Every licensee of a long-term care home shall ensure that staff members providing recreational and social activities in the home, (a) have a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university.

Findings:

1. A personal care staff provides recreational activities every other weekend for two hours. The staff person assigned commenced the role after July 1, 2010 and currently does not hold and is not enrolled in a program to obtain a diploma or certificate in the recreational and leisure field.

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WN #16: The Licensee has failed to comply with O.Reg 79/10 s.69(4)
Every licensee of a long term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:(4)Any other weight change that compromises the resident's health status.

Findings:

1. Documentation in an identified resident's health record, does not reflect that an interdisciplinary assessment was completed for a significant weight loss of 16.2% over three months. The resident did not have a February 2011 weight recorded in the health record, and documentation reflects the resident was eating poorly or refusing meals consistently since admission. There is no evidence that the registered dietitian was notified about the poor intake or significant weight loss and the resident has not been re-evaluated since admission. The resident was observed leaving the table and was not offered an entrée. The resident did not consume the lunch meal.

Inspector ID #:	107

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10 s.71(2)(b)
The licensee shall ensure that each menu, provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time.

Findings:

The homes menu cycle is repetitious and does not provide a variety of foods.

1. Week 1: peaches and pears are served six times within the week as well as served as part of the cottage cheese fruit plate and citrus fruit cup on Wednesday lunch and fruit cocktail Tuesday supper, bananas are served two days in a row and three times within the week Tuesday lunch, Wednesday supper, and Sunday lunch; mandarin oranges are served two days in a row Thursday and Friday supper, garden salad and caesar salad are served at the same lunch meal Tuesday, and there is no vegetable listed on the planned menu for the supper meal Wednesday.
2. Week 2: pudding is served twice in one day for Monday lunch and evening nourishment and Sunday supper and evening nourishment; pudding is served a total of six times within week two; squash is served two days in a row on Friday and Saturday supper, peaches and pears are served five times within the week as well as served as part of the cottage cheese fruit plate Sunday lunch and fruit cocktail Monday supper and Friday lunch, there is no vegetable listed on the planned menu for Thursday supper and sandwiches served during the lunch meals are also served for the evening nourishments on the following day. For example, Corn Beef sandwich is served Monday lunch and Tuesday evening nourishment, Egg salad sandwich is served Tuesday lunch and Wednesday evening nourishment, ham and cheese is served Wednesday lunch and Thursday evening nourishment and salmon salad sandwich is served Friday lunch and Saturday evening nourishment.
3. Week 3: peaches and pears are served four times within the week as well as served as part of the fruit cocktail Monday supper and Thursday lunch and fruit yogurt is served two days in a row Friday lunch and Saturday dinner.

Inspector ID #:	107 and 165

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 each menu, provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10 s.71(4)
The licensee shall ensure that the planned menu items are offered and available at each meal and snack.

Findings:

The licensee did not ensure that the planned menu items were offered and available at each meal.

1. The planned menu for texture modified diets clearly identifies an alternative choice for entrée, vegetable and dessert. An alternative entrée and vegetable for texture modified menus was not prepared and available at the lunch meal February 28, and March 8, 2011. It was confirmed by staff that only one choice is prepared and available at point of service for the texture modified menu. The Nutrition Manager confirmed that choice is not offered to residents requiring texture modified menus.
2. Residents requiring texture modified meals were not offered choice at the lunch meals February 28, and March 8, 2011. This was confirmed by staff and by a resident who stated they were no longer offered choice of menu items since their diet change to a pureed textured menu.
3. An identified resident was not offered a puree texture meal choice at the lunch meal March 8, 2011, despite the resident's plan of care stating staff are to give the resident two choices when presenting decisions, and to ask the resident questions that requires yes or no answers.
4. Multiple residents in the back of the dining room (where residents who require assistance and encouragement with eating sit) were not offered a choice of meal (regardless of their diet texture). Staff confirmed that residents that have some cognitive impairment or blindness are not offered choice at meals.
5. Only two residents were offered a choice of dessert during the lunch meal March 8, 2011. One resident identified to staff that they did not like the pudding dessert provided however staff encouraged the resident to eat the pudding and did not offer an alternative choice.
6. Five residents were not offered choice of entrees during the lunch meal March 8, 2011.
7. The planned menu states that tea/coffee, milk, and water are to be offered at each meal. Residents in the Restorative Dining program February 28, and March 8, 2011 were offered milk at the lunch meal; however, the other fluids were not available and offered to these residents.

Inspector ID #:	107,141 and 165

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 planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10 s. 72(3)(a)
The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality.

Findings:

Not all food and fluids are served using methods which preserve taste, nutritive value, appearance and

food quality. At the lunch meal February 28, 2011:

1. Staff were mixing tuna casserole and peas together on the plate or on the spoon for texture modified meals (minced and pureed textures), without the consent of residents.
2. Portions of menu items offered to residents were smaller than the planned menu portion size, reducing the nutritive value of the meal (e.g. 1/2 sandwich provided versus whole sandwich; #12 scoop provided versus a 6 oz ladle of minced and pureed tuna noodle casserole; #16 scoop provided versus #12 scoop minced green peas).
3. The Diabetic menu states 1/2 portion of the butterscotch pudding, however, residents requiring the diabetic menu were served diet pudding with a full portion. The nutritive value and portion size of the item offered was not consistent with the planned menu.

At the lunch meal March 8, 2011:

4. Residents receiving texture modified meals did not receive the same level of quality and palatability as residents receiving regular texture meals (for example, beef gravy was served over minced and pureed peas without the consent of the residents; a hot vegetable of minced peas was served with a cold egg salad sandwich - regular textured menus received salad).
5. Portions of menu items offered to residents were often smaller than the planned menu portion size (e.g. 1/2 sandwich versus whole egg salad sandwich; open faced hot beef sandwich versus two slices of bread on the sandwich; #16 scoop provided versus #12 scoop pureed and minced peas; #16 scoop provided versus #12 scoop for minced and pureed green peas).
6. Clear direction is not provided to dietary staff portioning meals in relation to portion sizes. Portion sizes are listed in four locations, including the planned menu; however, direction related to portion size is not consistent between the sources. Staff interviewed stated that portion size was not consistently followed.

Inspector ID #:	107 and 141

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 to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10 s.73(1)6,8,9,10

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: (6)Food and fluids being served at a temperature that is both safe and palatable to residents (8) Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs (9) Providing residents with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible (10)Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Findings:

1. Dessert was placed in front of residents while the resident's were still eating their entree during the lunch meal. An identified resident stopped eating the entrée and started to eat the dessert. The resident lost focus and began to alternate between the entrée and dessert. Neither course was fully consumed prior to the resident leaving the dining room. The plan of care did not direct staff to provide the entrée and dessert together.
2. An identified resident did not receive the required level of assistance with eating at the lunch meal. The resident had soup sitting in-front them, however, the resident left the table and was not re-directed to return and was not offered an entrée until identified by the Inspector at the end of the meal service.
3. An identified resident received intermittent assistance with eating however; the resident's plan of care states the resident requires total assistance with eating. The resident sat for extended periods in front

of the entrée and dessert when staff were assisting other residents at the same table and the resident did not eat independently.

4. An identified resident did not receive the required level of assistance with eating. The resident left the table without being re-directed to stay and complete the meal. The resident ate poorly.
5. An identified resident sat at the table sleeping with their fingers in their meal for an extended period of time. A staff member was sitting at the same table assisting other residents; however, the resident was not re-directed or encouraged. The resident then dropped the sandwich on the floor and was not assisted until identified by the inspector and a replacement was not provided. At 12:56pm staff placed the resident's beverages out of reach and staff did not intervene when the resident was struggling to reach the beverages until later in the meal. When the beverages were later placed in front of the resident the resident was able to drink them independently.
6. An identified resident has a plan of care that requires ongoing encouragement and physical assistance with meals, however, the resident was left sitting unsupervised and unassisted with beverages in front of them on two occasions. The resident did not consume all of the beverages. The resident's plan of care includes the use of an assistive device at meals; however the mat was not provided during the lunch meals. The plan of care also includes the resident is to be provided with intermittent encouragement and physical assist and the resident should be placed at a dining table where they can receive ongoing cueing and encouragement. On February 28, 2011 at the lunch meal the resident did not consume the main entrée and no encouragement or physical assist was provided. On March 8, 2011 at the lunch meal the resident was not provided with any physical assist to finish the meal and was encouraged once to take a sip of fluid after one hour in the dining room. A sip of water was consumed before the resident was assisted from the dining room and solid intake was less than 50% of the meal.
7. During the lunch meal on February 28, 2011 the resident was not provided with cueing or encouragement to complete the meal or fluids. During the lunch meal on March 8, 2001 the resident was not provided with cueing or encouragement until one hour after the meal commenced which at this time the resident took a small sip of milk before being assisted from the dining room. Review of the resident health records indicates that resident has had low fluid intake. The resident's plan of care states the resident is to be provided with supervision and occasional cueing to finish food and fluids and to provide extra encouragement to drink fluids as resident has history of poor fluid intake.
8. On February 28, 2011 at the lunch meal the resident did not receive constant assistance and did not complete intake of the main entrée. On March 8, 2011 at the lunch meal the resident was attempting to eat salad and dessert at the same time with a fork without staff redirection or assistance. The resident was not provided any assistance for one hour at which time a staff member encouraged and assisted the resident to drink the orange juice before being assisted from the dining room. Review of the resident records indicates the resident has had lower fluid intake than required on 12 of 16 days. An identified resident's plan of care includes the resident to be provided with supervision and constant assistance to finish food and fluids.
9. An identified resident was served soup at 11:48 hours on March 8, 2011 and did not receive encouragement or assistance until 12:05pm. The resident's plan of care identifies the resident is on restorative feeding and staff are to assist with all meals.
10. An identified resident did not receive an assistive device for the lunch meal March 8, 2011 however; interventions on the resident's care plan indicate the resident is to receive the assistive device to facilitate self-feeding.
11. Proper techniques were not always used to assist residents with eating at the lunch meal February 28, 2011. Staff were observed standing to feed a resident; an identified resident was not placed in an upright position; staff assisting the resident were scraping the resident's mouth with the spoon and overloading the spoon with large amounts of food while feeding the resident in a hurried manner.
12. At the supper meal March 8, 2011, beverages (milk and water) were left on tables for over 45 minutes in advance of meal service, reducing palatability of the beverages. Staff confirmed that the Home's policy is not to place beverages on tables more than five minutes in advance of the meal service.
13. At the lunch meal March 8, 2011, pudding was left sitting unrefrigerated on a tray for both meal sittings

(over 1.5 hours). Staff confirmed that the Home's policy is for foods that require refrigeration to be obtained as needed and not to be sitting out for the entire meal service.

Inspector ID #:	141 and 107

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 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: providing residents with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10 s. 73(2)(b)
The licensee shall ensure that, (b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Findings:

At the lunch meal March 8, 2011 residents who required total assistance with eating were served a meal prior to someone being available to provide the assistance.

1. Soup was placed in front of three residents prior to staff being available to assist the residents. Soup was placed on tables with no assistance being provided for over five minutes.
2. Beverages were placed on tables for all residents requiring assistance with eating and drinking prior to someone being available to provide the assistance.

Inspector ID #:	141 and 107

WN #22: The Licensee has failed to comply with O.Reg 79/10 s.76(1)
Every licensee of a long-term care home shall ensure that there is at least one cook who works at least 35 hours per week in that position on site at the home.

Findings:

1. The home currently does not have at least one cook who works at least 35 hours per week in that position on site at the home. The current cook position employs multiple staff to work 32.5 on-site hours per week.

Inspector ID #:	107

WN #23: The Licensee has failed to comply with O.Reg 79/10 s.78(1)
Every licensee of a long-term care home shall ensure that food service workers hired on or after the day this section comes into force, other than cooks to whom section 76 applies, have successfully completed or are enrolled in a Food Service Worker program at a college established under the Ontario Colleges of Applied Arts and Technology Act, 2002 or a Food Service Worker program provided by a registered private career college and approved by the Superintendent of Private Career Colleges under the Private Career Colleges Act, 2005.

Findings:

1. The licensee did not ensure that food service workers hired on or after the day this section came into force, have successfully completed or are enrolled in a Food Service Worker training program at an established college as listed in the Ontario Colleges of Applied Arts and Technology Act, 2002 or a registered private career college in Ontario. Two staff members were hired after July 1, 2010 to be

employed in the role of food service worker. Neither staff member has completed or is currently enrolled in the food service worker training program.

Inspector ID #:	107

WN #24: The Licensee has failed to comply with O.Reg 79/10 s.8(1)(b)
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, is complied with.

Findings:

1. The home did not follow their falls management policy (4.1.12) in relation to the response and documentation of an identified resident's fall. The home did not investigate the circumstances of the fall at the time of the incident and implement immediate interventions within the first 24 hours to prevent additional falls as indicated in the home's policy. The investigation of the fall incident was not completed until one month later and the resident sustained falls on two other occasions. The resident's plan of care was not updated until three weeks later despite indication in the homes policy to develop a comprehensive falls care plan within 1-7 days after the fall.

Inspector ID #:	165

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 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, and is complied with, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with O.Reg 79/10 s. 109(d)
Every licensee of a long term care home shall ensure that the home's written policy under section 29 of the Act deals with, (d) types of physical devices permitted to be used.

Findings:

1. The home's bedrails policy (in the Resident Services manual, Section Resident Safety 4.13, Subsection bedrails 4.1.3c), identifies the potential use of bed rails as a restraint however; this policy is not in accordance with section 29 of the Act. The restraint policy (in the Resident Services manual, Section 4.1 Resident Rights and Safety, Subsection restraints 4.1.3), does not include bedrails as an approved restraint for use in the home.
2. Staff confirmed they do not identify the use of bedrails as an approved restraint.

Inspector ID #:	107 and 165

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 every licensee of a long term care home shall ensure that the home's written policy under section 29 of the Act deals with, types of physical devices permitted to be used, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la

	responsabilisation et de la performance du système de santé. Revised for the purpose of publication - Sept 29, 2011
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).