Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2019	2019_556168_0019	006800-19, 006801-19	Follow up

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

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

Hardy Terrace
612 Mount Pleasant Road, R.R. #2 BRANTFORD ON N3T 5L5

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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 27, 30, 2019, October 1, 2, and 3, 2019.

Inspector Stacey Guthrie, inspector number #750 also conducted this inspection.

The following intakes were inspected during this Follow Up inspection:
Log # 006801-19 regarding Ontario Regulation (O. Reg.) 79/10, section (s.) 8(1) (b) related to policies to be followed, with a Compliance Due Date (CDD) of July 24, 2019,
Log # 006800-19 regarding Long-Term Care Homes Act (LTCHA) s.6(10) related to plan of care, with a CDD of July 24, 2019.

This inspection was conducted concurrently with Critical Incident Inspection, Inspection Number 2019_546750_0013.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Food Service Manager (FSM), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspectors observed the provision of care and reviewed records including but not limited to: clinical health records, policies and procedures, audit schedules and results, training records, staff participation records and tracking tools.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

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

3 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2019_556168_0006	168

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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 policies and procedures included in the required Dietary Service and Hydration Program were complied with.

In accordance with LTCHA s.11(1)(b) the licensee was to ensure that there was an organized program of hydration for the home to meet the hydration needs of residents.

O. Reg. 79/10, s. 68(1)(b) required the licensee to have an organized program of hydration and O. Reg. 79/10 s. 68(2) required the licensee to ensure that the program included the development and implementation of policies and procedures related to nutrition care and dietary services and hydration: including the identification of any risks related to nutrition care and dietary services and hydration; the implementation of interventions to mitigate and manage those risks and a system to monitor and evaluate the fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the policy and procedure "Hydration Assessment and Management", which was not numbered or dated; however, the Administrator identified that they created the policy and procedure and it was implemented in June 2019.
This document, which referred to the computerized documentation system of Point Click Care (PCC) directed:
"4. All intake of fluid is to be recorded in Point of Care (POC).
6. A resident whose intake is less than the fluid requirements calculated by the RD for three (3) consecutive days is assessed by the Registered Nursing Staff and includes being placed on the Fluid Watch Program except those exempt including enteral nutrition/tube feeding, fluid restrictions and palliative residents.
7. The fluid watch program includes:

a. a hydration plan of care to encourage fluids.
b. the night RN/RPN will complete a Nutrition Referral Form to inform the RD and Nutrition Manager that the fluid watch program has been initiated.
c. the day RPN will complete a Dehydration Risk Assessment,
i. if signs or symptoms of dehydration are not present, continue monitoring of fluid watch program.
d. if the fluid goal is met for seven (7) consecutive days, the Registered Staff will discontinue the fluid watch and complete a Nutrition Referral to notify RD/NM.
e. If by day seven (7), resident continues to not meet fluid goal for seven (7) consecutive days then another Dehydration Risk Assessment is completed by the day RPN and a Nutritional Referral Form is sent to the RD to indicate that the resident has not met their fluid goals for seven (7) days and that the fluid watch program is continuing.
i. If a resident remains on fluid watch for an extended period or is frequently on/off fluid watch, an RD referral is to be sent. The RD assesses the resident within seven (7) days of receiving the referral, initiates interventions as appropriate and re-assesses as appropriate."

Interview with the Administrator and DOC indicated that the policy and procedure Hydration Assessment and Management, was the current policy and procedure in the home and that it replaced the former policy and procedure "referral to Dietitian and or Director of Dietary Services, LTC-NAM-E-10.10, effective date January 2015".

A. According to the plan of care, with an effective date in July 2019, resident #017 was identified at a specified nutritional risk and had an estimated fluid need of a specified amount of milliliters (ml) a day.
Following a re-assessment, the resident was identified at another nutritional risk, according to their plan of care, with an effective date in August 2019.
A review of the Point Of Care (POC) records and progress notes from August 2019, until September 2019, identified that the resident did not consistently achieve their targeted fluid goal.
The resident was documented below their targeted fluid intake goal, for periods of 72 hours or greater on four specified dates between August and September 2019.
i. A review of the POC records did not include any documentation of fluid (amount consumed, if declined, if sleeping, if nothing by mouth or if resident on leave of absence) during nine meal or snack services between August and September 2019.
The DOC reviewed the POC records for August and September 2019, on request and confirmed that there was information not documented, as required, related to the resident's intake. The DOC identified that an auditing process was in place in an effort to

ensure that all fluids, including supplements were recorded in POC.
ii. A review of the clinical records did not include any referrals for the resident's low fluid intake in the months of August or September 2019, as confirmed during record review by RPN #115.
iii. The DOC confirmed that in accordance with the policy and procedure the resident should have had at least four referrals to the RD between the months of August and September 2019, based on the documented fluid intake and their assessed targeted fluid intake goal, for their fluid intake, following a review of the POC records.
iv. A progress note, dated on a specified date in August 2019, by RPN #107, identified that the resident did not meet their fluid requirement for three (3) days and included an assessment that the resident did not demonstrate signs or symptoms of dehydration; however, also noted that "referral to RD not required as daily fluid requirement was recently updated by RD as well as plan of care".
Interview with the RPN confirmed that a referral was not submitted, as to their recall there was a referral previously submitted for fluid intake and that they would not submit a referral to the RD every three days, if they did not consistently meet their goal.
There was no documentation, during the time period that the resident was on the "fluid watch program".
v. There was no documentation in the progress notes from an identified date in September 2019 until six days later that the resident was on the fluid watch program nor a dehydration risk assessment as confirmed during an interview with the DOC, following a review of the progress notes.
vi. On an identified date in September 2019, RPN #120 documented in the progress notes that staff continued "to encourage fluids and meals" and the following date, documented that "on this shift had very good food and fluid intake".
vii. On an identified date in September 2019, a progress note by RN #121 identified that the resident was on the "fluid hydration list". There was no documentation of a Dehydration Risk Assessment completed during the time period as confirmed by the DOC, following a review of the clinical record.
viii. A progress note, on an identified date in September 2019, by RN #121, identified that the resident was on the "fluid hydration list" and that staff continued to monitor; however, there was no documentation of a Dehydration Risk Assessment completed, as confirmed by the DOC, following a review of the clinical record.

B. According to the plan of care resident #016 was identified at nutritional risk, received an intervention three times a day and was assessed by the registered dietitian (RD) for a fluid requirement of a specified amount of ml a day.
A review of the POC records and progress notes for approximately two weeks in

September 2019, identified that the resident did not consistently achieve their targeted fluid goal. The resident was documented below their targeted fluid intake for periods of 72 hours or greater consecutively, on three specified dates in September 2019.
RPN #107 verified that fluid intakes were all documented in POC.
i. A review of the clinical record did not include any referrals for the resident's low fluid intake in September 2019, as confirmed by the DOC during a record review.
ii. Interview with the FSM and RD #118 identified that they were unaware of any recent referrals for the resident related to hydration, following a review of the POC records.
iii. A review of progress notes did not include any assessments of the resident related to dehydration risk assessment nor being on the fluid watch program for the time period.
iv. Interview with the RD #118 and DOC, following a review of POC records confirmed that according to the current policy and procedure "Hydration Assessment & Management", it was the expectation that a referral be submitted to dietary services for the resident when their target fluid intake was not met for three (3) or greater consecutive days and the home had not complied with the policy and procedure.

C. According to the plan of care resident #018 was identified at nutrition risk and had an estimated fluid need of a specified amount of ml per day.
A review of the POC records and progress notes identified that since, an identified date in July 2019, the date on the "Fluid Intake form" the resident did not consistently achieve their targeted fluid intake goal.
RPN #115 and RN #116 confirmed that a specified document was a record of the residents' daily fluid intake targets.
The resident was documented below their targeted fluid intake for a period of 72 hours or greater consecutively on five specified dates from July until September 2019.
i. A review of the clinical record included two "Interdisciplinary Team Referral Forms" for the Dietitian/Food Service Supervisor for a noted change in health status, low fluids and an expected outcome to increase fluid intake.
ii. A review of progress notes written by RPN #107, on one date in August and two dates in September 2019, indicated that the resident was assessed for not meeting their daily fluid intake for three (3) days, dehydration risk assessment completed; however, also noted "referral to RD not required".
Interview with RPN #107 confirmed that referrals were not submitted, as to their recall there was a referral previously submitted for fluid intake and that they would not submit a referral to the RD every three days, if they did not consistently meet their goal.
iii. The resident was assessed by the RD on a specified date in August 2019 and an intervention was ordered.
The following day another intervention was ordered by the physician for 24 hours.

iv. A review of progress notes recorded on three dates in August 2019 and two dates in September 2019, by RN #121, identified that the resident was placed on the "fluid hydration list" and that staff continued to monitor; however, there was no documentation or evidence of Dehydration Risk Assessments completed, as confirmed by the DOC, following a review of the clinical record.
v. Progress notes dated on two dates in September 2019, indicated that the resident was on a "fluid hydration list" and dehydration risk assessment completed; however, no referrals were submitted to the dietary department, as confirmed by the DOC, following a clinical record review.
vi. A quarterly nutrition assessment was completed on an identified date in August 2019, with no changes made.
vii. Interview with the DOC, following a clinical record review, confirmed that according to the "Hydration Assessment and Management" policy, staff did not comply with the expectation to complete a dehydration risk assessment and submit a referral to the dietitian/food service manager once a resident was placed on the "fluid hydration list".

The policy and procedure was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plans of care set out clear directions to staff and others who provided direct care to residents, #011 and #016, related to their fluid

requirements.

A. According to the plan of care resident #016 was at nutritional risk and had a fluid requirement of a specified amount of milliliters (ml) a day.
The plan also included a problem statement related to skin integrity and directed staff to encourage a fluid intake of at least another specified amount of ml a day.
In addition to the plan of care, the home maintained an untitled document, utilized by night staff, to determine if residents' achieved their individual minimum daily fluid requirement. The Administrator indicated that this form, the Fluid Assessment Form, identified resident specific, minimum daily fluid requirement values and was to be compared nightly with the resident's Dietary Reports. Actions would be taken, as appropriate, if necessary, for a resident with a less than desired individual fluid intake, based on the home's Hydration Assessment and Management procedure.
The Fluid Assessment Form noted the resident's minimum daily fluid requirement was a third specified amount of ml a day.
The DOC, following a review of the plan of care and Fluid Assessment Form confirmed that the plan did not give clear direction regarding the desired fluid intake and communicated their plan to review and revise the Fluid Assessment Form.

B. According to the plan of care resident #011 required a level of assistance for all meals and snacks.
The plan of care included problem statements for dehydration, nutritional risk and constipation.
The problem statements did not give clear direction to staff and others who provided direct care to the resident related to the desired fluid needs.
In addition to the plan of care, the home maintained an untitled document, utilized by night staff, to determine if residents' achieved their individual minimum daily fluid requirement. The Administrator indicated that this form, the Fluid Assessment Form, identified resident specific, minimum daily fluid requirement values and was to be compared nightly with the resident's Dietary Reports. Actions would be taken, as appropriate, if necessary, for residents with less than desired individual fluid intake, based on the home's Hydration Assessment and Management procedure.
The plan related to dehydration noted that the resident required a specified fluid amount a day.
The plan related to nutritional risk noted a goal for the resident to meet their target fluid requirement, from beverages, for a specified amount of ml a day, which was 80 percent (%) of their total fluid requirement.
The plan related to constipation directed staff to provide a minimum of a third specified

amount of ml of fluids per day as per meal and snack plan.
The Fluid Assessment Form noted the resident's minimum daily fluid requirement was a fourth specified amount of ml a day.
The DOC, following a review of the plan of care and the Fluid Assessment Form confirmed that the plan did not give clear directions to staff, regarding the desired fluid intake and noted that the plan had since been revised. The DOC also shared their plan to review and revise the Fluid Assessment Form.

The plans of care did not set out clear directions to staff and others who provided direct care to residents related to desired fluid intake. [s. 6. (1) (c)]

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 plan of care sets out clear directions to staff and others who provide direct care to residents related to their care needs, to be implemented voluntarily.

WN #3: 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 that, resident #011, who exhibited altered skin integrity, 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.

According to a progress note, dated in August 2019, resident #011 had an injury of unknown origin, discovered when doing rounds, which was documented by RN #110.
Interview with RN #110 confirmed that they did not visually observe the area nor complete an assessment; however, recorded the observation of PSW #112.
Interview with PSW #112 confirmed the presence of the injury on the identified shift.
A review of the clinical record did not include an assessment of the area, nor additional documentation regarding the injury of unknown origin.
Interview with the DOC identified that they were previously unaware of the injury and the expectation that the RN would have assessed the resident and the area.

The area of altered skin integrity was not assessed by registered nursing staff, with a clinically appropriate assessment instrument which was designed for skin and wound assessment. [s. 50. (2) (b) (i)]

Issued on this 23rd day of October, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care 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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168)
Inspection No. / No de l'inspection :	2019_556168_0019
Log No. / No de registre :	006800-19, 006801-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 23, 2019
Licensee / Titulaire de permis :	Diversicare Canada Management Services Co., Inc. 2121 Argentia Road, Suite 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	Hardy Terrace 612 Mount Pleasant Road, R.R. #2, BRANTFORD, ON, N3T-5L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deborah Langlois

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

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

To Diversicare Canada Management Services Co., Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2019_556168_0006, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with section 8(1) of Ontario Regulation 79/10.

Specifically, the licensee must:
1. Review and revise their policy and procedure Hydration Assessment and Management.
The revisions, at a minimum, shall include:
-reference to the current computerized documentation system in the home;
-all supporting documents and tools, referenced in the procedure, shall be identified as appendicies to the policy and procedure, with all documents identified by title;
-documentation expectations when a resident is on the Fluid Watch Program; and
-the expectation of a "Dehydration Risk Assessment".
2. Provide training to all nursing staff regarding the revised policy and procedure Hydration Assessment and Management.
Specifically, this training shall include who is to submit a Nutrition Referral Form, when and how a Nutrition Referral Form is to be submitted, who is responsible for and how to maintain the Fluid Assessment Form and documentation and assessment expectations when on the Fluid Watch Program.
3. Records of the training shall be maintained for each active nursing staff member at the home including the date of completion.
The records, including the exact number of active nursing staff, at the time of the compliance due date (CDD), of the Compliance Order (CO), shall be produced on request.
4. The licensee shall comply with their policy and procedure Hydration Assessment and Management, for residents #016, #017 and #018, and any other resident.
5. Develop and implement an auditing process of all residents who do not meet their targeted fluid level for three or greater consecutive days, to ensure that staff are following the policy and procedure.
This audit shall initially be completed at least weekly until the home achieves a 90 percent compliance with the policy and procedure, at which time the audits may be completed at a frequency as determined by the home.
6. Records of all audits completed and the corrective action taken shall be maintained in the home and produced on request.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

1. A Complaint Inspection, Inspection Number 2019_556168_0006 (A2) and dated April 3, 2019, included a Compliance Order (CO) #001 for O. Reg 79/10 s. 8(1)b.
The order included:
The licensee must be compliant with s 8(1)b of Ontario Regulation 79/10.
Specifically the licensee must:
1. Review their policy and procedure Referral to Dietitian and or Director of Dietary Services, LTC-NAM-E-10.10, effective date January 2015, to ensure that it is up to date and reflective of the expectations of the licensee. Revisions shall be made to the policy and procedure as appropriate.
2. Provide training to all nursing staff regarding the policy and procedure and expectations including: assessments to be completed, how to complete the assessments
and when and how to submit a referral to dietary services.
3. Comply with their policy and procedure Referral to Dietitian and or Director of Dietary Services, LTC-NAM-E-10.10.
4. Develop and implement an auditing process to ensure that staff are following the policy and procedure, to be completed at times and frequencies as determined by the home. Records of the audits and actions taken shall be maintained.

The home completed section #1 of CO #001 from Inspection Report 2019_556168_0006 (A2).
The home failed to complete sections #2, #3 and #4, of CO #001 from Inspection Report 2019_556168_0006 (A2).

1. The licensee failed to ensure policies and procedures included in the required Dietary Service and Hydration Program were complied with.

In accordance with LTCHA s.11(1)(b) the licensee was to ensure that there was an organized program of hydration for the home to meet the hydration needs of residents.

O. Reg. 79/10, s. 68(1)(b) required the licensee to have an organized program of hydration and O. Reg. 79/10 s. 68(2) required the licensee to ensure that the program included the development and implementation of policies and procedures related to nutrition care and dietary services and hydration: including

the identification of any risks related to nutrition care and dietary services and hydration; the implementation of interventions to mitigate and manage those risks and a system to monitor and evaluate the fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the policy and procedure "Hydration Assessment and Management", which was not numbered or dated; however, the Administrator identified that they created the policy and procedure and it was implemented in June 2019.
This document, which referred to the computerized documentation system of Point Click Care (PCC) directed:
"4. All intake of fluid is to be recorded in Point of Care (POC).
6. A resident whose intake is less than the fluid requirements calculated by the RD for three (3) consecutive days is assessed by the Registered Nursing Staff and includes being placed on the Fluid Watch Program except those exempt including enteral nutrition/tube feeding, fluid restrictions and palliative residents.
7. The fluid watch program includes:
a. a hydration plan of care to encourage fluids.
b. the night RN/RPN will complete a Nutrition Referral Form to inform the RD and Nutrition Manager that the fluid watch program has been initiated.
c. the day RPN will complete a Dehydration Risk Assessment,
i. if signs or symptoms of dehydration are not present, continue monitoring of fluid watch program.
d. if the fluid goal is met for seven (7) consecutive days, the Registered Staff will discontinue the fluid watch and complete a Nutrition Referral to notify RD/NM.
e. If by day seven (7), resident continues to not meet fluid goal for seven (7) consecutive days then another Dehydration Risk Assessment is completed by the day RPN and a Nutritional Referral Form is sent to the RD to indicate that the resident has not met their fluid goals for seven (7) days and that the fluid watch program is continuing.
i. If a resident remains on fluid watch for an extended period or is frequently on/off fluid watch, an RD referral is to be sent. The RD assesses the resident within seven (7) days of receiving the referral, initiates interventions as appropriate and re-assesses as appropriate."

Interview with the Administrator and DOC indicated that the policy and procedure Hydration Assessment and Management, was the current policy and

procedure in the home and that it replaced the former policy and procedure "referral to Dietitian and or Director of Dietary Services, LTC-NAM-E-10.10, effective date January 2015".

A. According to the plan of care, with an effective date in July 2019, resident #017 was identified at a specified nutritional risk and had an estimated fluid need of a specified amount of milliliters (ml) a day.
Following a re-assessment, the resident was identified at another nutritional risk, according to their plan of care, with an effective date in August 2019.
A review of the Point Of Care (POC) records and progress notes from August 2019, until September 2019, identified that the resident did not consistently achieve their targeted fluid goal.
The resident was documented below their targeted fluid intake goal, for periods of 72 hours or greater on four specified dates between August and September 2019.
i. A review of the POC records did not include any documentation of fluid (amount consumed, if declined, if sleeping, if nothing by mouth or if resident on leave of absence) during nine meal or snack services between August and September 2019.
The DOC reviewed the POC records for August and September 2019, on request and confirmed that there was information not documented, as required, related to the resident's intake. The DOC identified that an auditing process was in place in an effort to ensure that all fluids, including supplements were recorded in POC.
ii. A review of the clinical records did not include any referrals for the resident's low fluid intake in the months of August or September 2019, as confirmed during record review by RPN #115.
iii. The DOC confirmed that in accordance with the policy and procedure the resident should have had at least four referrals to the RD between the months of August and September 2019, based on the documented fluid intake and their assessed targeted fluid intake goal, for their fluid intake, following a review of the POC records.
iv. A progress note, dated on a specified date in August 2019, by RPN #107, identified that the resident did not meet their fluid requirement for three (3) days and included an assessment that the resident did not demonstrate signs or symptoms of dehydration; however, also noted that "referral to RD not required as daily fluid requirement was recently updated by RD as well as plan of care".

Interview with the RPN confirmed that a referral was not submitted, as to their recall there was a referral previously submitted for fluid intake and that they would not submit a referral to the RD every three days, if they did not consistently meet their goal.
There was no documentation, during the time period that the resident was on the "fluid watch program".
v. There was no documentation in the progress notes from an identified date in September 2019 until six days later that the resident was on the fluid watch program nor a dehydration risk assessment as confirmed during an interview with the DOC, following a review of the progress notes.
vi. On an identified date in September 2019, RPN #120 documented in the progress notes that staff continued "to encourage fluids and meals" and the following date, documented that "on this shift had very good food and fluid intake".
vii. On an identified date in September 2019, a progress note by RN #121 identified that the resident was on the "fluid hydration list". There was no documentation of a Dehydration Risk Assessment completed during the time period as confirmed by the DOC, following a review of the clinical record.
viii. A progress note, on an identified date in September 2019, by RN #121, identified that the resident was on the "fluid hydration list" and that staff continued to monitor; however, there was no documentation of a Dehydration Risk Assessment completed, as confirmed by the DOC, following a review of the clinical record.

B. According to the plan of care resident #016 was identified at nutritional risk, received an intervention three times a day and was assessed by the registered dietitian (RD) for a fluid requirement of a specified amount of ml a day.
A review of the POC records and progress notes for approximately two weeks in September 2019, identified that the resident did not consistently achieve their targeted fluid goal. The resident was documented below their targeted fluid intake for periods of 72 hours or greater consecutively, on three specified dates in September 2019.
RPN #107 verified that fluid intakes were all documented in POC.
i. A review of the clinical record did not include any referrals for the resident's low fluid intake in September 2019, as confirmed by the DOC during a record review.
ii. Interview with the FSM and RD #118 identified that they were unaware of any

recent referrals for the resident related to hydration, following a review of the POC records.
iii. A review of progress notes did not include any assessments of the resident related to dehydration risk assessment nor being on the fluid watch program for the time period.
iv. Interview with the RD #118 and DOC, following a review of POC records confirmed that according to the current policy and procedure "Hydration Assessment & Management", it was the expectation that a referral be submitted to dietary services for the resident when their target fluid intake was not met for three (3) or greater consecutive days and the home had not complied with the policy and procedure.

C. According to the plan of care resident #018 was identified at nutrition risk and had an estimated fluid need of a specified amount of ml per day.
A review of the POC records and progress notes identified that since, an identified date in July 2019, the date on the "Fluid Intake form" the resident did not consistently achieve their targeted fluid intake goal.
RPN #115 and RN #116 confirmed that a specified document was a record of the residents' daily fluid intake targets.
The resident was documented below their targeted fluid intake for a period of 72 hours or greater consecutively on five specified dates from July until September 2019.
i. A review of the clinical record included two "Interdisciplinary Team Referral Forms" for the Dietitian/Food Service Supervisor for a noted change in health status, low fluids and an expected outcome to increase fluid intake.
ii. A review of progress notes written by RPN #107, on one date in August and two dates in September 2019, indicated that the resident was assessed for not meeting their daily fluid intake for three (3) days, dehydration risk assessment completed; however, also noted "referral to RD not required".
Interview with RPN #107 confirmed that referrals were not submitted, as to their recall there was a referral previously submitted for fluid intake and that they would not submit a referral to the RD every three days, if they did not consistently meet their goal.
iii. The resident was assessed by the RD on a specified date in August 2019 and an intervention was ordered.
The following day another intervention was ordered by the physician for 24 hours.

iv. A review of progress notes recorded on three dates in August 2019 and two dates in September 2019, by RN #121, identified that the resident was placed on the "fluid hydration list" and that staff continued to monitor; however, there was no documentation or evidence of Dehydration Risk Assessments completed, as confirmed by the DOC, following a review of the clinical record.
v. Progress notes dated on two dates in September 2019, indicated that the resident was on a "fluid hydration list" and dehydration risk assessment completed; however, no referrals were submitted to the dietary department, as confirmed by the DOC, following a clinical record review.
vi. A quarterly nutrition assessment was completed on an identified date in August 2019, with no changes made.
vii. Interview with the DOC, following a clinical record review, confirmed that according to the "Hydration Assessment and Management" policy, staff did not comply with the expectation to complete a dehydration risk assessment and submit a referral to the dietitian/food service manager once a resident was placed on the "fluid hydration list".

The policy and procedure was not complied with. [s. 8. (1) (b)]

The severity of this issue was determined to be a level 2 as there was the potential for actual harm to the residents.
The scope of this issue was a level 3 as it was widespread and related to 3 of 3 residents.
The home had a level four (4) compliance history with this section of the LTCHA that included:
-voluntary plan of correction (VPC) November 21, 2017, report 2017-695156-0002;
-a compliance order (CO) April 03, 2019, report 2019_556168_0006(A2) with a compliance due date of July 24, 2019; and
-a VPC August 21, 2019, report 2019_541169_0015. (168)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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