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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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
February 7, 8, 9, 10, 11, 2011	2011_107_2776_01Feb145437 2011_107_2776_01Feb145415	Follow Up H-00224 CI-2776-000002-11 H-00300

Licensee/Titulaire
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Long-Term Care Home/Foyer de soins de longue durée
Heritage Green Nursing Home

Name of Inspector(s)/Nom de l'inspecteur(s)
Michelle Warrener - #107

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up inspection related to nutritional care and dietary services and to conduct a critical incident inspection related to resident care.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Assistant Director of Care, Staff Development Co-ordinator, Registered Dietitian, residents, nursing and dietary staff on all three floors.

During the course of the inspection, the inspector: Observed resident care, meal service at the breakfast, lunch and dinner meals, the afternoon snack pass, interviewed residents and staff members, and reviewed resident clinical health records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Food Quality
Safe and Secure Home
Nutrition and Hydration
Accommodation Services – Housekeeping

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

[17] WN
[6] VPC
[8] CO: CO #001-008

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

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 LTCHA, 2007, S.O. 2007, c.8, s.5
5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Findings:

1. **February 7, 2011 10:12a.m. in the third floor dining room (Rosewood), the servery was left unattended with steam coming out of the steam table. Residents were in the dining room and the door to the dining room was left unlocked and accessible. The servery does not contain a barrier to prevent access to this area.**
2. **Coffee machines/hot water in dining rooms on the first and third floors remain accessible to residents during times these areas are unsupervised.**

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Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.24(1)2
24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:

1. **The licensee did not report to the Director when there were reasonable grounds to suspect abuse of a resident as documented in an identified resident's health record. This incident was not reported to the Director.**

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WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)(c)
6(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective

Findings:

1. **An identified resident's plan of care related to assistance required for eating was not revised when the resident's care needs changed. The plan of care states the resident requires minimal set up assistance with meals, however, documentation in the progress notes indicates the resident has required full feeding assistance and encouragement at multiple meals. The resident did not eat without assistance and encouragement at the meals observed by the Inspector. The resident's plan of care does not reflect the increased level of assistance required.**
2. **An identified resident's hydration status was not re-assessed and the plan of care revised when the specified goals related to hydration were not being met. The resident consumed less than their target beverage intake on 19/19 days reviewed in January, 2011 (average of 640ml/day for 18 days). An interdisciplinary assessment of the resident's hydration has not been completed with a plan to address the fluid deficit.**
3. **An identified resident's hydration status was not re-assessed and the plan of care revised when the plan of care related to hydration was not effective for the months of December 2010 and January 2011. The resident did not meet hydration targets for 24/31 days in December and**

25/31 days in January. An assessment of the poor hydration was not completed with a plan implemented to address the fluid deficit.

4. **The plan of care for an identified resident was not re-assessed and revised when the resident was documented as consuming more fluids at the breakfast meal and daily than their plan of care indicated for the month of January 2011. The resident consumed more than the specified amount of fluid at each meal on 22/30 days at the breakfast meal, 6/24 days at the lunch meal, and on 5 days at the evening snack.**
5. **An identified resident's plan of care was not reviewed and revised when the care set out in the plan in relation to the resident's hydration status has not been effective. The resident's food and fluid intake monitoring records show that the resident has been below their target beverage intake on all days recorded for both December 2010 and January 2011 (28/28 days each month). The resident's hydration status has not been assessed and the plan of care revised since the quarterly review in December, 2010. The resident's plan of care identified the resident is at risk for fluid volume deficit and to monitor for signs and symptoms of dehydration. An assessment to identify the reason for the reduction in hydration has not been completed and measures are not in place to correct the fluid deficit.**
6. **An identified resident was not re-assessed and the plan of care reviewed and revised when the resident was not meeting their target beverage intake. The resident did not meet their target beverage intake on 22/30 days for the month of January 2011. A referral to the Registered Dietitian was not initiated and the poor hydration was not evaluated by the multidisciplinary team. The plan of care was not revised to address the resident not meeting target hydration requirements.**
7. **The plan of care for an identified resident was not revised when there was a change in the resident's care needs. The plan of care related to Advanced Directives was not revised to reflect the resident's current status.**
8. **The plan of care for related to Sleep/Rest pattern for an identified resident has not been revised to reflect the resident's change in status.**

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Additional Required Actions:

CO # - 002 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(7)
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:

The care set out in the plan of care was not provided to 17 residents at the lunch meal February 7, 2011:

- **A resident has a plan of care stating no gravy to be added to food, however, the resident had gravy added to the meal. The resident is not able to voice preferences.**
- **A resident has a plan of care for a pureed texture diet however, they received minced meat.**
- **A resident requires a High Energy High Protein (HEHP) menu with the addition of high protein (HP) milk at meals and a preference for milk, however, the resident did not receive milk or high protein milk with the meal.**
- **A resident has a plan of care requiring small portions, however, a regular portion of food was provided**
- **A resident has a preference for milk to drink, however, milk was not provided**

- A resident has a plan of care requiring an extra glass of water at lunch, however, this was not provided
- A resident has a plan of care requiring a regular texture meal, however, a minced textured meal was provided. The resident did not eat the minced meal and was then provided with a regular textured sandwich.
- A resident has a plan of care requiring HEHP menu, however, HP milk was not provided. The resident had significant weight loss in January 2011.
- A resident has a requirement for HP milk at meals, however, this was not provided
- A resident has a requirement for a supplement at lunch and for a moist minced menu, however, the supplement was not provided and the minced meat did not have a sauce.
- A resident has an order for a moist minced menu, and thickened fluids however, a pureed menu was provided with a different consistency of thickened beverages than required on the resident's order. The resident is unable to voice preferences.
- A resident has an order for a minced texture menu, however, regular texture was provided to the resident. Staff confirmed this was in error.
- A resident prefers soymilk at meals, however, this was not offered to the resident. The resident requested a glass of soymilk when speaking with the Inspector.
- A resident requires a supplement at lunch, however, this was not provided.
- A resident requires a specialized menu, however, the resident confirmed that the special menu choices were not offered. The resident received items which were contrary to the planned therapeutic menu.
- A resident has a plan of care requiring double desserts at lunch. The resident confirmed that two desserts were not offered.
- A resident requires HP milk with all meals, however, this was not provided

The care set out in the plan of care was not provided to seven residents at the supper meal February 7, 2011:

- A resident requires HP milk with meals, however, this was not provided
- A resident requires minced texture, however, was provided regular texture.
- A resident has a plan of care that states the resident dislikes gravy, however, gravy was put on the resident's meat, potatoes and carrots. The resident is unable to voice preferences. The resident requires a HEHP menu, however, milk was not provided with the meal.
- A resident requires that dessert be served at the same time as the main meal, however, this was not provided. The resident left the dining room and did not eat.
- A resident has a plan of care requiring soup at the supper meal, however this was not provided. The resident is unable to voice preferences.
- A resident requires a HEHP menu, however, HP milk was not provided
- A resident requires thickened fluids, however, the incorrect texture of thickened fluids was provided. The plan of care states to provide minced texture and if not tolerated to try pureed texture. The resident was only offered a pureed texture meal.

The care set out in the plan of care was not provided to the following residents at the lunch meal February 9, 2011:

- Residents requiring high protein milk did not receive it. Dietary staff confirms that the HP milk was not available and had not been prepared for the lunch meal.
- A resident has an order for thickened fluids, however, the incorrect consistency of fluids was provided. The resident's plan of care states no dairy products, however, milk was provided.

The following residents did not receive the care set out in the residents' plans of care:

1. The care set out in the plan of care was not provided to an identified resident in relation to toileting. The resident's plan of care requires two staff to transfer onto/off the toilet with a

mechanical lift and the resident is not to be left unattended on the toilet. The resident was transferred onto the toilet with one PSW (Personal Support Worker) and was left unattended while on the toilet. (Verified by Management, Registered staff and PSW interviews).

2. **An identified resident has a plan of care that requires the calculation of total fluid intake daily and to report intake of < 1000ml to the charge nurse. The resident did not have their total fluid intake calculated on 20/31 days in January 2011, and documentation does not reflect that fluid intake of less than 1000ml/day was reported to the charge nurse (18/19 days in January 2011). The resident had a significant weight loss of 8.8% over one month (January to February 2011).**
3. **The care set out in the plan of care by the Registered Dietitian in November, 2010 was not provided to an identified resident. In November 2010 the Registered Dietitian wrote an order for the resident's nutritional supplement to be increased, however, this order was not implemented. The resident continued to receive the previous order in December 2010 and until the end of January 2011 when the Registered Dietitian wrote another order for the same increase. During this time, the resident has had significant weight loss (8% in January 2011) and was not meeting hydration requirements for most of December 2010 and January 2011.**
4. **An identified resident has a plan of care requiring a specified amount of fluids. For the month of January 2011, the resident is often documented as consuming more fluids than their specific fluid plan allows on 22/30 days and this has not been evaluated. The resident's plan of care identifies the resident is to follow a specialized menu. The resident was offered the regular menu (confirmed with resident that the special menu was not offered) at the lunch meal February 7, 2011.**
5. **An identified resident has a plan of care that states that staff are to record the amount of fluid intake at meals and snacks (in ml), calculate total intake daily and record, and report intake < 1000ml to charge nurse. The documentation does not reflect that fluids were totaled daily (10 days in December 2010 the daily total intake was not calculated), resulting in reduced ability to identify inadequate fluid intake daily. The resident consumed < 1000ml on 6/28 days for both December 2010 and January 2011, however, this was not reported or evaluated. The resident's plan of care states the resident prefers milk with meals, however, milk was not provided at the lunch meal February 7, 2011. The resident received only water at the meal.**
6. **The care set out in the plan of care was not provided to an identified resident as specified in their plan. The resident had an order for an enteral feed to be provided. The quantity of formula provided to the resident and method for administering the enteral feeding were not consistent with the physician order. The Medication Administration Record (MAR) was not signed and did not reflect the actual enteral formula and method provided to the resident.**

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Additional Required Actions:

CO # - 003 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #5: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(8)
6(8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Findings:

1. **Staff who provide direct care to an identified resident did not have immediate access to the plan of care. The plan of care was recorded on the computer, however, staff providing direct care to the resident do not access the computer. A paper copy was not available in the resident's record for reference to those without computer access (as per the Home's policy and practice)**

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WN #6: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(9)1
6(9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

Findings:

1. **An identified resident has a plan of care that states the resident receives a bath twice weekly. Documentation in the resident's health records on the flow sheets does not reflect that a bath or shower was provided on five of the required days in January, 2011.**
2. **Documentation in the health record for an identified resident does not reflect the provision of two baths per week. The resident's plan of care states the resident receives a shower on a specified morning and a second bath at the resident's request. Documentation on the January 2011 flow sheets indicated only one shower was provided for the month. The resident was unable to confirm if baths were being provided.**
3. **The provision of care in relation to transferring for an identified resident was not documented for the month of January 2011. Flow sheets for monitoring the care provided in relation to transferring were not printed and available for staff for the month of January 2011 and documentation was not completed (verified that documentation was not completed through staff interview).**
4. **Documentation in the health record for two residents does not reflect the provision of blood glucose testing according the residents' plans of care:**
   - **An identified resident has an order for blood glucose testing on specified dates, however, blood glucose was not recorded for the first week of February 2011 (as per the Blood Glucose Monitoring record).**
   - **An identified resident has an order for blood glucose to be taken at specified dates and times. Blood Glucose Monitoring records were reviewed for November and December 2010 and numerous omissions were noted.**

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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 with ensuring that the provision of the care set out in the plan of care is documented.

WN #7: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.84
84 Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

Findings:

1. **A quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home is not in place. Management staff confirmed that a quality management system is not currently in place to monitor and evaluate the care and services provided by the home. Audits in the dietary department are not consistently being**

completed and data collected is not being analyzed with an action plan developed to improve quality.

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Additional Required Actions:

CO # - 004 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #8: The Licensee has failed to comply with O.Reg. 79/10, s.26(4)(a)(b)
26(4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).

Findings:

1. **At the January, 2011 nutritional assessment of an identified resident, the Registered Dietitian did not include an assessment of the resident's hydration status. Documentation on the resident's food and fluid intake flow sheets reflects that the resident did not meet hydration targets on 24/31 days for the month of December 2010 and 25/31 days for the month of January 2011. The resident's hydration status was not evaluated with a plan of action to address the poor hydration.**

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WN #9: The Licensee has failed to comply with O.Reg. 79/10, s. 69.1-4
69 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:
(1)A change of 5 per cent of body weight, or more, over one month.
(2)A change of 7.5 per cent of body weight, or more, over three months.
(3)A change of 10 per cent of body weight, or more, over 6 months.
(4)Any other weight change that compromises the resident's health status.

Findings:

1. **An identified resident had a significant documented weight loss in three months, however, the weight change has not been assessed by the multidisciplinary team. The resident was not weighed in January 2011 (verified through staff interview and documentation). A re-weight to verify the accuracy of the significant weight change has not been completed as yet (February 8, 2011), and documentation does not reflect the multidisciplinary team has assessed the significant weight loss. Staff interviewed by the Inspector identified that the resident had lost weight. The home's policy and procedure for weight monitoring was not followed.**
2. **An identified resident was not assessed using an interdisciplinary approach after a significant weight loss of 6.2% in January 2011 and an 8% loss over 3 months triggered in February 2011. A multidisciplinary assessment of the January weight change was not completed and a re-weight (to verify the accuracy of the significant weight change) was not completed (as per the Home's policy and procedure) and was not available for the Registered Dietitian when a nutritional assessment was commenced. After a re-weight was completed (as requested by the Registered Dietitian at the nutritional assessment), an assessment of the significant weight change was not completed. Further significant weight loss (8% over 3 months) was flagged by**

the computer the beginning of February 2011, however, an assessment of the significant weight change has not been completed as of February 10, 2011. When interviewed by the Inspector, the resident stated they felt like they had lost weight.

3. **An identified resident did not have their weight recorded in November 2010. The resident had an unplanned weight lost of 5.5% from October to December 2010, however, a re-weight for the December weight to verify accuracy was not completed. At the December, 2010 nutritional quarterly review the accuracy of the weight loss in December was questioned and a plan was not implemented to address the weight loss. The resident was underweight with a low body mass index (BMI). Notes of poor appetite/intake were documented in January 2011, however, no referral to the Registered Dietitian or follow up was completed in relation to the weight loss.**

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Additional Required Actions:

CO # - 005 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #10: The Licensee has failed to comply with O.Reg. 79/10, s.71(5)
71(5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle.

Findings:

1. **An individualized menu has not been developed for an identified resident to ensure that appropriate foods are planned and available for the resident at meals. The resident has multiple dietary restrictions, however, the home's menu includes foods the resident avoids.**
2. **The menu cycle does not include menus individualized for restricted vegetarian diets (Lacto-ovo, Lacto-vegetarian and Vegan). The Home is preparing vegetarian items, however, direction is not provided to staff preparing and serving the restricted vegetarian meals (e.g. does not ensure a variety of items is prepared and served to residents, information about portion size is not available, recipes are not available, direction is not provided on how to texture modify the items).**

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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 with ensuring that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg. 79/10, s. 72(2)(d)(g)
72(2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus
(d) preparation of all menu items according to the planned menu.
(g) documentation on the production sheet of any menu substitutions.

Findings:

1. **Not all menu items were prepared and served according to the planned menu and recipes. At the lunch meal February 7, the supper meal February 7, the breakfast meal February 9, and**

at the lunch meal February 9, 2011, foods prepared and served did not match the planned menu (also voiced as a concern from resident interview).
Some examples: mashed potatoes were prepared and served for texture modified menus instead of minced and pureed scalloped potatoes, resulting in reduced variety for the texture modified menus; the vegetarian menu was planned for salmon and stuffed cheese shells, however, vegetarian chicken strips were served for the regular menu and vegetarian minced and pureed ground meat (like veggie beef) was served resulting in reduced variety as veggie ground meat was again served at the lunch meal a day later and direction about portion size or acceptability of each item for each diet type was not available to staff portioning the meals; a pureed corned beef sandwich with a cabbage and carrot salad was planned, however, a pureed hot meal with meat, mashed potatoes and carrots was served; pureed soup was not offered to residents requiring a pureed menu, however, was offered to residents requiring a regular menu at the supper meal; high energy high protein milk was not provided at the supper meal and two lunch meals (at the lunch meal Feb 9, 2011 the high protein milk was confirmed as not prepared); fresh cantaloupe and pureed waffles were not prepared or available as per the planned menu at the breakfast meal (Food committee meeting minutes support that residents want fresh fruits with the breakfast meal). An alternative was not provided.

3. **Some items prepared (diabetic fruit crisp, grilled salmon, and chicken cacciatore) were not the same as the planned recipes.**
4. **Standardized recipes and production sheets were not available to guide staff in the consistent preparation and service of the vegetarian items served to residents.**
5. **The texture of some pureed menu items was chunky or runny, creating a potential choking risk for residents (chunky pureed salad, and pureed vegetarian; runny pureed wax beans and broccoli)**
6. **Menu substitutions were not documented on the production sheet on February 7, 2011. Staff confirmed that menu changes are not consistently documented on production sheets and that a record of menu substitutions was unavailable for review by the Inspector.**

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Additional Required Actions:

CO # - 006 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #12: The Licensee has failed to comply with O.Reg. 79/10, s. 72(3)(a)
72(3)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:

1. **Not all foods were served using methods which preserve taste, appearance and food quality at the lunch meal February 7, 2011, supper meal February 7, 2011, and lunch meal February 9:**

- **Residents requiring a texture modified menu (minced or pureed) were not provided the same level of quality as for the regular texture menu. Residents receiving the regular texture menu received salmon with a dill sauce at the lunch meal February 7, 2011, however, residents requiring a minced or pureed menu received salmon with brown gravy. Residents requiring the minced and pureed menus were also served gravy on their vegetables without the consent of the residents at the lunch and supper meals February 7, 2011. Some of the residents who received gravy on their texture modified meals have a plan of care that specifically states dislikes gravy, and the residents are unable to voice their preferences at point of service.**
- **Some residents requiring texture modified menus who were being assisted with eating at the**

supper meal February 7, 2011 and the lunch meal February 9, 2011 had their meals stirred/mixed together on the plate.
- **Appropriate utensils were not available for the lunch meal service resulting in portions of food being served to residents that were less than the planned menu (reduced nutritive value of the meal).**

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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 with ensuring 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 #13: The Licensee has failed to comply with O.Reg. 79/10, s.73(1)9,10
73(1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any 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. **At the supper meal February 7, and 10, 2011 eight residents did not receive the required level of assistance with eating, as per their plans of care and observed needs.**
2. **At the lunch meals February 7 and 9, 2011, not all residents received the required assistive devices that were specified on their plan of care:**
   - **Two identified residents did not receive adaptive cutlery**
   - **An identified resident did not receive a lipped plate and had difficulty with the regular plate provided (food spilling over the table and resident's lap)**
   - **An identified resident did not receive the required non-slip mat**
3. **February 7, 2011 - An identified resident was sitting in their wheelchair for over one hour with a styrofoam container of pureed snack sitting on arm of their wheelchair (from the 10am snack pass). The resident did not consume the snack and requires total assistance with eating.**
4. **Proper techniques were not used to assist residents with eating at the supper meal February 7, 2011:**
   - **Residents were fed in a rushed manner without giving adequate time for each resident to swallow between bites and to be fed in a safe manner.**
   - **A staff member assisting an identified resident was standing to feed the resident.**

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Additional Required Actions:

CO # - 007 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #14: The Licensee has failed to comply with O.Reg. 79/10, s.73(2)(a)(b)
73(2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(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:

1. **At the supper meal February 7, 2011, there were two staff members available to assist seven residents who required total assistance with eating. Staff members were observed moving from table to table and rushing while feeding residents.**
2. **At the supper meal February 7, 2011, several residents sat with food in-front of them (one resident for more than 25 minutes) without assistance being provided. Four of these residents did not eat well at the observed supper meal.**

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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 with ensuring that no person simultaneously assists more than two residents who need total assistance with eating or drinking and that 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, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg. 79/10, s. 8(1)(b)
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,
(b) is complied with.

Findings:

1. **The home's weight monitoring policy and procedure states that residents will be weighed on the resident's bath day the first week of each month and recorded on the tubroom weight worksheet. The Restorative Care Aide is to enter weights from the tubroom worksheet into the computerized record, compares to the previous month, and if the weight measurement appears questionable, re-weighs the resident. The Registered Staff are to record the current, correct weight on the resident's clinical record for weight and reviews the computerized report which indicates whether weight change is significant for one, three and six months. The significant weight change is then reported to the Physician (using doctor's communication log) and Dietary Manager (using nursing-dietary communication form). Records in resident's progress notes, on 24 hours report and in weight communication binder.**
   This policy was not followed for the following residents (weight monitoring records reviewed February 9, 2011 for the period of November 2010 to February 2011):
   - **A weight was not taken for four identified residents**
   - **A weight was not recorded in the residents' clinical health records for 21 identified residents**
   - **A re-weight to verify the accuracy of the weight was not taken for 14 identified residents with significant weight loss.**
2. **The Home's policy and procedure for completion of food and fluid intake monitoring records was not followed for an identified resident for the month of January 2011. Nineteen**

entries were missing/incomplete for the month, daily quantities of fluids were not totaled for 27/31 days

3. **The Home's policy and procedure related to completion of care flow sheets for bathing was not followed for the month of January 2011 for an identified resident. Only one bath per week was recorded. The resident had refused the second bath per week (as per discussion with the resident and staff), however, this was not recorded as being offered to the resident.**

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 with ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg. 79/10, s.87(2)(b)
87(2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs, and lift chairs and supplies and devices, including personal assistance services devices, assistive aids, and positioning aids and contact surfaces, using hospital grade disinfectant and in accordance with manufacturer's specifications.

Findings:

1. **On February 11, 2011 and throughout this review, numerous residents were observed to have dried debris on their wheelchairs and cushions/seatbelts of the wheelchairs. The wheelchairs were not kept clean.**
   A Management team member observed four of the wheelchairs with the inspector and verified the wheelchairs were heavily soiled and the soiling was not fresh.

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 with ensuring that procedures are developed and implemented for cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs, and lift chairs and supplies and devices, including personal assistance services devices, assistive aids, and positioning aids and contact surfaces, using hospital grade disinfectant and in accordance with manufacturer's specifications, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg. 79/10, s.91
91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

Findings:

1. **February 7, 2011 third floor Rosewood dining room at 10:12a.m - five bottles of chemicals (Rinsit x 2, Limeaway, CPS-490, Liquid Assure presoak) were stored in an unlocked cabinet**

under the hand-washing sink that was accessible to residents.

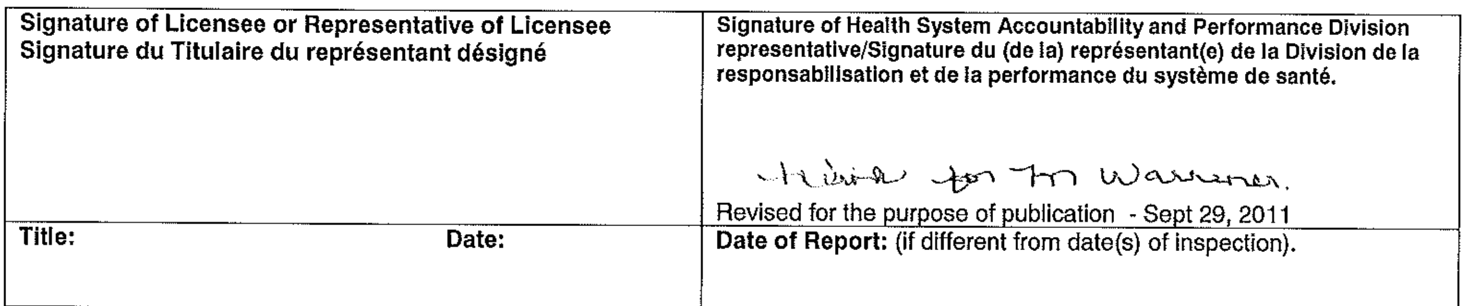
2. February 9, 2011 the tub room in the Magnolia home area was left unlocked and unattended at 12:15p.m. A bottle of Arjo disinfectant cleaner (poisonous and corrosive) was accessible to residents (on the floor of the tub room).

Inspector ID #: 107

Additional Required Actions:

CO # - 008 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

CORRECTED NON-COMPLIANCE Non-respects à Corrigé				
REQUIREMENT EXIGENCE	**TYPE OF ACTION/ORDER**	**ACTION/ ORDER #**	**INSPECTION REPORT #**	**INSPECTOR ID #**
LTCHA, 2007, S.O. 2007 c. 8, s.6(1)(c)	CO#1	#1	H-00542 - Nutrition Complaint August 11/10 related to hypoglycemia management	171
O3.1			Environmental Health June 24/10 related to sticky floors in the dining room	127
A1.11(2)			557-2010 - Nutrition Review June 10/10 related to resident's rights	107



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).