Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 7, 8, 12, 15, Apr 17, 18, 19, 23, 24, Jun 5, 6, 7, 8, 11, 12, 21, 25, 26, 28, Jul 11, 12, 2012	2012_066107_0006	Follow up

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

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

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, Assistant Administrator, Director of Care, Assistant Director of Care, Clinical Co-ordinator, Food Service Manager, Food Service Supervisor, Registered staff and front line nursing, including Registered Nurses (RN) and Personal Support Workers (PSW) and dietary staff on all floors, residents and family members

During the course of the inspection, the inspector(s) toured the home, reviewed identified residents' clinical health records, observed meal service in all dining areas, observed food production systems, and reviewed relevant policies and procedures related to follow up inspection H-000571-12.

Please Note: Complaint inspections H-001894-11, H-002427-11, H-000566-12 (report #2012_066107_0005 / H-001894-11) were completed concurrently with this follow up inspection and evidence related to these complaint inspections has been issued as part of this follow up inspection.

The following Inspection Protocols were used during this inspection:

Dining Observation

Food Quality

Nutrition and Hydration

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Quality Improvement

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(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. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)] Previously issued November 17, 2010 as a WN.
The plan of care for an identified resident did not set out clear directions for the staff and others who provided direct care to the resident. The resident's plan of care on the computer did not include information related to the resident's ordered nutritional supplements, however, the paper copy available to staff did include this information. The two plans of care were not consistent and staff interviewed provided conflicting information about the frequency of administration of the resident's nutritional supplement.
PLEASE NOTE: This evidence of non-compliance was found during inspection H-001894-11.

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued as a CO on February 7-11, 2011.
The licensee did not ensure that the care set out in the plan of care was provided to residents as specified in their plans.
Some examples:
1. At the lunch meal March 7, 2012:
a) Three residents were not offered special items as listed on their plans of care.

2. At the supper meal March 8, 2012:
a) All thickened fluids on the beverage cart were a certain consistency, however, some residents required a different consistency of thickened fluids. Staff did not adjust the consistency of the thickened fluids and the same consistency was provided to all residents requiring thickened beverages. Three observed residents received an incorrect consistency of thickened fluids (fluids and nutritional supplements) creating a risk for choking or reduced fluid availability.
b) An identified resident received the incorrect texture of entree. The resident's plan of care stated they required a pureed texture at meals, however, the resident was provided with a minced textured entree, creating a risk for choking.
c) An identified resident required thin fluids according to their plan of care, however, staff provided a mixture of fluid consistencies at the meal.
d) An identified resident's plan of care stated to provide a minced diet but if that texture was refused, to offer a regular textured meal. The resident was not offered a minced textured diet prior to providing a regular textured entree.
e) Two residents were not offered high protein milk, as per their plans of care.
f) Three residents did not receive special dietary interventions as per their plans of care.

3. At the lunch meal March 15, 2012:
a) Three residents received the incorrect texture of their meal, creating a risk for choking or an unnecessary downgrade in texture. Staff confirmed the items were provided in error and that the residents did not request them.
b) An identified resident received an incorrect consistency of thickened fluids creating a risk for aspiration.
c) Four residents received items that were contrary to their prescribed diet orders:
i) An identified resident required a fluid restriction at meals, however, they were provided with more fluids than the restriction allowed. Food and fluid intake documentation records reflected that the resident was consuming more fluids than the required restriction on 50/59 days over a two month period in 2012.
ii) An identified resident required a restricted menu, however, was provided foods that were restricted. The resident stated they weren't supposed to get the item that was provided to them. The therapeutic extension menu stated the resident was to receive a substitution at the meal.
iii) An identified resident required a restricted diet without a specific menu item, however, the item was provided to the resident and the resident stated it was given all the time.
iv) An identified resident had a plan of care that stated a specific item was not to be on the resident's table, however, the resident had the item beside them at the table.
d) Two residents received items they were not supposed to for safety or resident preferences. The residents were unable to voice their meal needs/preferences/dislikes.
e) Four residents were not offered items identified on their plans of care:
(specialized milk, extra water)

4. At the lunch meal April 17, 2012:
a) Three identified residents were provided items that were identified as dislikes on their plans of care.
b) An identified resident was not offered their preferred menu item as specified in their plan of care.

5. The care set out in the plan of care for an identified resident was not provided to the resident as specified in their plan.
a) The resident's plan of care stated a specific consistency of thickened fluids were required, however, the resident was

served a different consistency of fluids at all of their meals daily. This resulted in a mixed consistency of textures being served to the resident, creating a potential risk for choking. Staff confirmed the fluid was not thickened to the correct consistency.
b) The resident's plan of care stated to provide a specific type of milk at lunch daily and that the resident liked milk at meals, however, this was not offered to the resident at the lunch meal March 7, and supper meal March 8, 2012. The resident confirmed that milk was not offered at these meals.
c) The resident's plan of care stated that staff were to report to the Charge Nurse when the resident was consuming less than 1000ml per day. Documentation did not reflect that the charge nurse was routinely contacted when the resident's fluid intake was less than 1000ml/day. The resident consumed less than 1000ml/day 59% of the days over a two month period in 2012.
d) The resident's plan of care stated to offer water three times daily between meals. During interview the resident stated staff were not consistently offering the water between meals and the resident stated they were very thirsty. The resident was not meeting their hydration requirements 97% of the time over a two month period in 2012.

6. The care set out in the plan of care for an identified resident was not provided to the resident as specified in their plan. The resident's plan of care stated they required a specific consistency of thickened fluids. The resident was provided thin fluids at the supper meal March 12, 2012 and the PSW interviewed was unaware that the resident required thickened fluids. The thin fluid was removed, however, an alternative thickened beverage was not provided. The resident was also provided thin fluids at the lunch meal March 8, 2012. Registered staff removed the thin fluid when identified, however, a replacement was not provided/offered.

7. The care set out in the plan of care for an identified resident was not provided to the resident as specified in the plan.
a) The resident had a physician's order for a nutritional supplement several times daily with the medication pass. The order was not discontinued, however, the supplement was removed in error from the Medication Administration Records for one month in 2012, resulting in the resident not receiving the nutritional supplement. Staff did not identify the error. The resident was at high nutrition risk with poor food and fluid intake and a history of significant weight loss.
b) The resident had a physician's order for a nutritional supplement when food intake was poor or refused. The supplement was not provided as required when food intake was poor (as per the food intake records) at nine breakfasts, 14 lunches, and one supper meal over a 1.5 month period. The supplement was also given in a different quantity than what was specified in the physician order (given less).
c) The resident's plan of care stated to provide special foods at meals. The 2012 quarterly review by the Registered Dietitian stated Dietary was aware that special items must be available as an alternate choice if the resident was not able to eat/refused the entree. The special item was not available at the lunch meal April 17, 2012, requiring nursing staff to go to the kitchen to retrieve the item. The item was then not offered to the resident as required in the plan of care.
d) The resident ate poorly at the observed lunch meal April 17, 2012, however, the ordered nutritional supplement was not offered to the resident. Staff interviewed was not aware of the order for a supplement to be offered when food intake was poor.
PLEASE NOTE: This evidence of non-compliance was found during inspection H-001894-11.

8. The care set out in the plan of care for an identified resident was not provided to the resident as specified in their plan.
a) The resident's plan of care identified a requirement for a restricted menu. A memo posted in the dining room and in the nursing station also directed staff not to provide the restricted items. The resident was provided a restricted item by staff providing care.
b) The Registered Dietitian discontinued one type of supplement and replaced the order with a different type of supplement. The previous order was discontinued on the Medication Administration Record (MAR), however, the new order was not added to the MAR. The resident had not been receiving the ordered supplement for six months. The resident's wound was not healing well and was being treated with recommendations by a specialized wound care nurse.

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)] Previously issued as a CO on February 7-11, 2011.
The licensee did not ensure that the plans of care for four identified residents were revised when the residents' care needs changed.
a) The plans of care for three residents stated the residents ate all meals in the dining room, however, staff stated the residents routinely ate in their rooms for the supper meal.
b) An identified resident had a plan of care for specialized milk at all meals. The resident stated they never received the

milk at meals and did not like it at lunch and supper. Their plan was not revised to reflect the preferences of the resident.

4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(a)]
Staff involved in the different aspects of care of an identified resident did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. The Nutrition Status Resident Assessment Protocol (RAP), completed by the Food Service Manager stated the plan of care was effective, however, the nutrition quarterly assessment completed by the Registered Dietitian identified that the resident was not meeting their daily hydration target. The Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment completed by nursing did not code for insufficient fluid intake, resulting in a Dehyration/Insufficient Fluid RAP not being triggered, however, food and fluid intake records reflect the resident had been consuming less than 1000ml per day the week prior to the RAI-MDS assessment. Progress notes completed by nursing stated the resident was drinking well. Food and fluid records reflected the resident had not met their hydration target on any day over a 1 month period. The information in the progress notes, RAI-MDS coding, food and fluid intake records, Registered Dietitian assessment and Food Service Manager assessment was not consistent in regards to the resident's hydration status.

5. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(b)]
Staff and others involved in the different aspects of care of an identified resident did not collaborate with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.
a) The resident had a plan of care for a specialized restricted menu. A memo was also placed in the dining room which instructed staff not to provide certain restricted items. The physician initiated a supplement (which contained the restricted items), however, this information was not communicated to the Registered Dietitian for assessment. The directions to staff were not consistent (e.g. do not provide the restricted item, but also to provide a supplement containing the restricted item).
b) The resident's plan of care identified the resident was on a fluid restriction, however, another section of the plan directed staff to provide increased fluids during hot weather. The different sections of the plan were not consistent.

Additional Required Actions:

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

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 sections 6(1)(c),6(4)(a)(b), and 6(10)(b), are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 84] Previously issued as a CO on February 7-11, 2011.
A quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home had not been fully implemented for the dietary department. Management staff interviewed confirmed that quality management activities were not consistently being completed in the dietary department and data collected was not being analyzed with an action plan developed to improve quality. The licensee was unable to fully implement their corrective action plan submitted to the Ministry of Health and Long Term Care related to outstanding compliance orders for non-compliance within the home. Several compliance orders have been issued a consecutive time during this inspection.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
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. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 69.1] Section 69.1-4 previously issued as a CO on February 7-11, 2011. This was also issued under the Program Standards Manual as B3.24 on June 10, 2010.
The licensee did not ensure that action was taken and outcomes were evaluated for an identified resident after a significant weight loss. The resident's plan of care identified a goal for the prevention of weight loss or to maintain their weight within a specified target body weight range. At the nutrition assessment, the Registered Dietitian noted the resident had a significant weight loss of 18% to below their target weight range, and that the resident had decreased food intake over the quarter, however, action was not taken to address the significant weight loss. Interventions identified on the resident's plan of care were not evaluated for effectiveness and outcomes were not evaluated in relation to the goal for weight maintenance/prevention of weight loss.
2. [O.Reg. 79/10, s. 69.4]
The licensee did not ensure that an identified resident had actions taken and outcomes evaluated after an undesirable 6.5% weight loss over a three month period in 2012. The weight loss was noted, however, the plan was to continue with the same interventions. The goal on the resident's plan of care was for weight maintenance within their specified target body weight range, however, the resident had not been within this weight range for several years. Outcomes were not evaluated in relation to care planning goals and the current status of the resident.
3. [O.Reg. 79/10, s. 69.1]
The licensee did not ensure that a significant weight change of 33.1% in one month was assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated for an identified resident. A re-weigh to verify the accuracy of the weight did not occur and an assessment of the significant weight change did not occur that same month. Follow up on the weight did not occur until the quarterly review scheduled the next month, however, the next months weight was not available/taken. An accurate assessment of the resident could not be completed and interventions could not be accurately evaluated for effectiveness.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 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; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 72(3)(a)] Previously issued as a VPC on February 7-11, 2011.
Not all food and fluids were prepared, stored, and served using methods that preserved taste, nutritive value, appearance and food quality.
a) An identified resident was not provided with appropriate sauces for their entrees to ensure the appearance and taste of the meal were preserved while providing additional moisture to the food. During interview the resident identified that their meals did not always taste good with the sauce provided by the home and they would prefer more appropriate sauces be used for their foods when additional moisture was needed.
b) Three residents receiving pureed texture meals had their entrees mixed together by staff providing assistance with eating. Staff interview confirmed that the residents had not requested their meals mixed together and it was not part of their plans of care. Two identified residents stated they did not like part of their lunch meal March 7, 2012, which was now mixed together with the other items on the residents' plates and the residents ate poorly.
c) Not all staff preparing the lunch meal March 15, 2012 were following the planned recipes to ensure taste, nutritive value, appearance and food quality were preserved. Some examples: additional spices were added to the gravy and carrots, however, it was not written down which spices were added, resulting in variations in flavour and appearance when different cooks prepared meals and potential for unidentified allergens; water was added to the pureed chicken fingers which was less nutrient dense and less tasty than the broth or gravy that was in the planned recipe, the liver was coated with a flour and spice mixture prior to cooking, however, this was not included on the recipe.
d) Foods prepared for the lunch meal March 15, 2012 were prepared too far in advance of meal service, resulting in reduced nutritive value and quality. Minced and pureed broccoli/cauliflower were finished cooking and hot held from 1000 hours for the 1230 lunch meal; minced and pureed chicken fingers were cooked at 1030hours for the lunch meal at 1230 hours, while the regular texture chicken fingers were cooked later; minced and pureed carrots were prepared at 1030 hours for the lunch meal and hot held until the lunch meal; the vegetarian entree was hot held on the stovetop from 1000 hours until the 1230 hour lunch meal.
e) A sufficient quantity of fresh potatoes were unavailable for the lunch meal, resulting in the substitution of instant mashed potatoes, which were not of the same quality and taste as the fresh potatoes. The cook stated she added butter and seasoning to the regular potatoes, however, nothing was added to the instant potatoes.

2. [O.Reg. 79/10, s. 72(2)(d)] Previously issued as a CO on February 7-11, 2011. Previously issued June 10, 2010 under the Nursing Homes Act Chapter N.7, Section 20.11 related to un-met criterion P1.14.

Not all menu items were prepared according to the planned menu, resulting in variations in flavour, nutritive value, and variety. Some examples:
a) The following items were not prepared:
pureed rice pilaf, pureed greek salad (indicated on the therapeutic extension menu, however, production sheets indicated hot pureed vegetable), pureed garlic bread, pureed whole wheat bread,2 x boiled potatoes for the renal menu (cook stated that the renal diets could have the mashed potatoes, which was contrary to the planned menu).
b) The following item varied from the planned menu:
the alternative vegetarian choice prepared was chicken alternative, however, the planned menu stated vegetable stew.

Additional Required Actions:

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

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 are prepared, stored, and served using methods that preserve taste, nutritive value, appearance and food quality,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 91] Previously issued as a CO on February 7-11, 2011.
Not all hazardous substances were kept inaccessible to residents on March 7, 2012 at 1205 hours. The door to a tub room was left ajar with no staff present in the hallway or in the tub room. The inspector was able to enter the tub room where there was an accessible bottle of disinfectant cleaner (corrosive). After 10 minutes staff came in and stated the door automatically locked, however, on this occasion, the door did not lock automatically and was significantly delayed in closing when staff left the room.

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
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 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.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 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. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)9] Previously issued as a CO on February 7-11, 2011. Previously issued as B3.32 under the Program Standards Manual June 10, 2010.
Not all residents were provided with the required eating aides, assistive devices, and personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
a) An identified resident had a plan of care stating they required total assistance with eating if the resident was not willing to feed themselves. The resident sat with their meal in-front of them for over 1 hour without assistance or encouragement being provided. The resident was high nutritional risk.
b) An identified resident had a plan of care requiring total assistance with eating, however, assistance was not provided to the resident until the end of the lunch meal March 7, 2012 and the resident ate poorly. Assistance with eating was also not provided at the lunch meal March 12, 2012, and the morning and afternoon snack pass April 18, 2012. At the morning snack pass the resident sat for over one hour with their beverage in-front of them. At the afternoon snack service, the resident placed the beverage in the railing beside their wheelchair and sat without consuming the beverage. The resident did not consume more than a teaspoon of their beverages at the identified snack passes. The day prior, the resident's family member fed them their morning beverage and the resident consumed the beverage.
c) An identified resident's plan of care stated staff were to return several times to provide the resident with encouragement to eat and finish their meal or the resident would leave the dining room without completing the meal. The resident did not receive encouragement with eating and the resident left the dining room without eating and before dessert was offered.
d) An identified resident did not receive assistive devices at the supper meal March 8, 2012 as per their plan of care. The resident sat at the table for over 50 minutes waiting for their meal and for feeding assistance to be provided.
e) An identified resident did not receive assistance with opening their beverage carton, as per the resident's plan of care. The container sat on the table and the resident did not consume it.

2. [O.Reg. 73(1)5] Previously issued as a VPC on February 7-11, 2011.
A process to ensure that food service workers and other staff assisting residents were aware of the residents' current diets, special needs and preferences, was not in place.
a) Information provided to staff on the dining room serving lists was not always consistent with the residents' plans of care and needs, and information on the serving lists was sometimes conflicting/not clear. Some examples:
i) two identified residents had conflicting information related to diet type/texture (diet listed on the serving list was inconsistent with the resident's ordered diet)
ii) three identified residents had conflicting information related to preferences (diet list specified the resident disliked certain items but also instructed staff to provide those items)
iii) six identified residents had conflicting information related to level of assistance required for eating at meals (not consistent with their plan of care, not consistent with the current level of assistance actually required)
b) The serving list in the second floor dining room did not reflect the names of two residents who only occasionally ate meals in that dining room, who were eating the supper meal March 8, 2012.
c) A process was not in place during an outbreak to ensure that new admission diet information was communicated to staff serving in the second floor dining room. Staff interview confirmed that a resident was admitted on a Friday, however, the diet list was not updated until the Monday and the resident received items that were contrary to the resident's planned diet order.

3. [O.Reg. 79/10, s. 73(2)(b)]
a) At the lunch meal March 7, 2012, an identified resident had their meal placed in-front of them at the same time as food was placed for their tablemate. The staff assisting the resident completed feeding the tablemate prior to assisting this resident. The resident's food remained sitting on the table in-front of them.
b) Residents who required assistance with eating and drinking had their fluids placed on the table prior to the residents getting to the dining room at the supper meal March 8, 2012. The fluids were left sitting on the tables for an extended time until staff were available to assist the residents.

4. [O.Reg. 79/10, s. 73 (1)6] Previously issued as B3.30 under the Program Standards Manual June 10, 2010.
Food was not served at a temperature that was both safe and palatable to the residents at the supper meals March 8 and March 12, 2012. Some hot food items were left sitting on the counter or sitting on-top of other pans in the steam table during the meal service (not sitting in the steam table as required), resulting in food temperatures not being maintained. Food temperatures were taken just after the last resident received their entree. Temperature monitoring

records indicated that hot foods were to be served above 140 degrees Fahrenheit (F). On March 8, lamb souvlaki was probed at 120 degrees Fahrenheit (F), pureed lamb souvlaki was probed at 110 degrees F, pureed thickened soup was probed at 100 degrees F (this item was available, however, did not end up being served to residents). On March 12, 2012 pureed corn was left sitting on the counter the entire meal service. Staff interviewed stated there was not enough room in the steam table to fit all of the items. A resident who was interviewed stated that meals were often cold at both lunch and supper meals.

5. [O.Reg. 79/10, s. 73(1)10] Previously issued as a CO on February 7-11, 2011.
Proper techniques, including safe positioning of residents who required assistance with eating were not provided to residents at the observed supper meal March 8, 2012.
a) An identified resident was being fed by staff while in their room. The resident was not in an upright position and their chin was pointed towards the ceiling (not tucked for safe swallowing). The resident was coughing while being assisted with their thickened fluids. The inspector asked the staff to reposition the resident prior to continued feeding.
b) An identified resident was being fed by staff while in their room. The resident's bed was not in an upright position and the resident stated they were having difficulty swallowing.

6. [O.Reg. 79/10, s. 73(1)11]
Appropriate seating for staff that were assisting residents to eat was not in place at the observed lunch meal April 17, 2012. Staff assisting an identified resident was using a wooden stool that was in poor condition and too high for staff assisting the resident. The staff member had to lean over while feeding the resident and they were not in a position that was safe and comfortable.

Additional Required Actions:

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

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 sections 73(1) 5,6,11, and 73(2)(b), are complied with, to be implemented voluntarily.

WN #7: 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 subsections:

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).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 8(1)(b)] Previously issued as a VPC on February 7-11, 2011.
The licensee of the home did not ensure that the policy, protocol and procedure related to weight monitoring was complied with by staff providing care to residents.
a)The Home's policy 05-02-07a "Weighing and Reweighing" stated that all residents would be weighed monthly and that weights were to be taken on the bath day during the first week of the month, no later than the 7th of each month. If weights were questionable, the Restorative Care Aide was to re-weigh the resident and re-weighs were to be completed no later than the 9th of each month.
b) The Home's policy was not followed for an identified resident. A 33% weight gain was recorded over one month in 2012 (not entered within the first 7 days), however, a re-weigh to confirm the accuracy of the weight was not completed. The resident did not have their weight taken or recorded the next month. The resident's quarterly review was scheduled for the month the weight was not taken, and a weight was not available for the Registered Dietitian assessment and the previous month's weight had questionable accuracy, resulting in the inability to complete an accurate assessment of the resident.
c) The licensee of the home did not ensure that the home's policy related to weight monitoring was complied with for an identified resident. The resident had an 8.1% significant weight loss over one month in 2012, however, a re-weigh to verify the accuracy of the weight did not occur. Documentation did not support rationale for not completing the re-weigh.
d)The licensee of the home did not ensure that the home's weight monitoring policy was complied with for an identified resident. The resident had a significant weight loss of 18% noted over one month in 2012. A re-weigh, to verify the accuracy of the significant weight loss was not completed as per the Home's policy.
e) At least 29 residents on one floor did not have their weights taken and recorded in their electronic record within the first week for one month in 2012.
f) A re-weigh, verifying the accuracy of a significant weight change was not completed and entered into the electronic health record for at least 15 residents on one floor over a four month period.

2. [O.Reg. 79/10, s. 8(1)(a)]
a) The Home's policy related to High Energy High Protein (HEHP) diet orders was not clear and did not specify what the home's HEHP protocol was. Residents had diet orders stating "High Energy High Protein", however, staff interview confirmed that the protocol was not clear and could not be readily evaluated for effectiveness (e.g. did not include specific items to provide, number of kcal/protein the additional items would provide, etc.)
b) The Home's hydration policy did not provide clear direction to staff related to when to refer a resident to other health care professionals, including the Registered Dietitian, and potential strategies to increase hydration.

3. [O.Reg. 79/10, s. 8(1)] Previously issued as a VPC on February 7-11, 2011.
The licensee of the home did not ensure that the protocol related to treatment of hypoglycemia was complied with by staff providing care to two identified residents. Management staff interviewed stated the policy and protocol was placed in the Medication Administration Record binder, however, on the first and third floors the policy was not in the binder. Not all staff were familiar with the Home's protocol when interviewed and staff were not providing treatment as outlined in the protocol.
a) The Home's "Hypoglycemia Protocol" stated:
- For capillary blood sugar (CBG) values between 2.8-4.0 staff were to provide 15g carbohydrate, recheck the CBG in 15 minutes, and if the CBG was not > 4.0 to give another 15g carbohydrate and recheck in another 15 minutes. If the CBG was not > 4.0 then go to the severe hypoglycemia protocol. If the CBG was 4.0 at any point in the process, staff are to continue to check the CBG every 15 minutes until a meal or meal equivalent is eaten. Then check 2 hours after the meal and if CBG is normal, resume usual testing schedule for that resident.
- For CBG < 2.8 but resident is conscious give 20 g carbohydrate, recheck CBG in 15 minutes. If CBG < 4.0 give another 20 g carbohydrate and recheck CBG in 15 minutes. If CBG is still < 4.0 go to severe hypoglycemia protocol. If the CBG was 4.0 at any point in the process, staff are to continue to check the CBG every 15 minutes until a meal or meal equivalent is eaten. Then check 2 hours after the meal and if CBG is normal, resume usual testing schedule for that resident.
- Severe Hypoglycemia protocol - CBG < 2.8 and resident is unconscious or uncooperative give 1mg glucagon and call 911. Recheck CBG in 15 minutes. If CBG < 4.0 give another 1mg glucagon. Recheck in 15 minutes and if < 4.0 paramedics can give Dextrose D50W IV. If after glucagon resident becomes conscious but CBG still < 4.0 give 15 g oral carbohydrate. If CBG 4.0 continue to check every 15 minutes.
Examples of 15 g carbohydrate:

15 g glucose in tablet form, 3 packets or tsp of table sugar dissolved in water, 3/4 c juice or regular pop, 3 tsp honey, 3 sugar cubes, 6 lifesavers, 9 jelly beans
20 g sugar: 4 tsp table sugar/packets dissolved in water, 1 cup juice or regular pop, 4 tsp honey, 8 lifesavers.
A meal equivalent includes:
- cheese and crackers, 1 slice of bread with 1 tbs of peanut butter, or 1/2 c milk and cereal, needs to be given if next meal is more than 1 hour from now.
b) Staff providing care for an identified resident did not follow the above protocol for five incidents of hypoglycemia over a five month period.
c) Staff providing care to an identified resident did not comply with the Home's policy/protocol for nine incidents of hypoglycemia over a four month period.

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 home's policies are in compliance with and are implemented in accordance with all applicable requirements under the Act and are complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(4)]
Not all residents were offered the planned menu items at each meal.
a) Residents receiving texture modified meals were not offered a choice from the planned menu items at the lunch and dinner meals March 8, 2012 and the lunch meal April 17, 2012. Staff confirmed the alternative meal choice was not routinely offered for the pureed menu. During interview, an identified resident who required a texture modified meal confirmed that they were not routinely provided a choice in menu items at meals and stated staff routinely served the resident food and fluids that were dislikes. At the lunch meal April 17, 2012, an identified resident who required a textured modified meal had a specified dislike, however, meal choice was not offered and the dislike was given to the resident. The resident was also not offered a choice of dessert; staff chose for the resident. Staff were observed asking for meals by diet texture versus by menu preference. E.g. "I need a pureed for Mr. X" versus "I would like chicken, mashed potatoes and corn for Mr X". Two identified residents requiring a texture modified lunch meal March 7, 2012, who were not offered a choice of meal stated they did not like the entree provided to them. The planned alternative entree was not offered to the residents and they ate very little. An identified resident had a plan of care stating the resident was able to communicate (in a language other than English), however, a verbal or visual meal choice was not offered to the resident at the dinner meal May 8, 2012. An identified resident had a plan of care stating "give resident 2 choices when presenting decisions", however, the resident was not offered a choice of meal at the dinner meal May 8, 2012.
b) Pureed bread was not offered to residents requiring a pureed textured meal as per the planned menu at the lunch meals March 7 and April 17, 2012. The pureed bread was prepared but not served on March 7 and was not prepared or available as per the menu on April 17. Staff interview confirmed that the pureed bread was not routinely offered unless nursing staff asked for it. Regular bread was not offered to residents at the lunch meals March 15 and April 17, 2012, as per the planned menu.
c) Not all residents were offered the planned beverages identified on the menu. The planned menu for the lunch and dinner meals identified milk, tea or coffee was to be available and offered to residents. Several residents were offered only one beverage at multiple meals, which would not facilitate meeting their hydration requirements. Milk was not offered to residents at the lunch meals March 7, 8, April 17, 2012, supper meal March 8, and thickened milk was not offered to residents at the lunch meals March 7, 8, 15, and April 17, and the supper meal March 8, 2012, as per the planned menu. Coffee/tea was not routinely offered to residents requiring thickened fluids or to residents requiring assistance with eating/drinking.
d) Residents requiring tray service were not offered soup, as per the planned menu at the supper meal May 8, 2012. An identified resident had a plan of care that indicated the resident enjoyed soup, tea with milk and and sugar, and milk to drink. The resident was not offered the soup, milk or tea.
e) The planned portion size for menu items was not consistently followed by staff serving meals. Some examples: the planned portion of pureed grilled cheese was a #10 scoop of grilled cheese served with a #12 scoop of bread, however, the item was prepared together and served with only a #12 scoop; white bean fiesta salad was planned with a 125ml portion (#8 scoop), however, a smaller #10 scoop was used; pureed lamb souvlaki was planned with a #10 scoop, however, a smaller portion of #12 scoop was used; a #10 scoop of pureed meatballs was planned, however, a #8 scoop was served; the planned diabetic menu required 1/2 breadstick, however, a whole breadstick was served.
f) Residents receiving a pureed texture dinner meal March 8, 2012 did not receive the same quality of meal as the regular textured meal and items served to residents did not follow the planned menu. Some examples: pureed grilled cheese was served with a side of mashed potatoes and a hot vegetable with gravy poured over all of the items. The menu stated the grilled cheese was to be served with a white bean fiesta salad and gravy was not included on the planned menu. Gravy was not served with the regular textured grilled cheese or salad.
g) The planned soup (vegetable soup) for the supper meal May 8, 2012 was available, however, an alternative soup (tomato) was offered to residents.

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. [O.Reg 79/10, s. 129(1)(a)(ii)]
a) On Apr 17, 2012, at 1054 hours, the medication room on the second floor was left open - drawers to both medication carts were left unlocked and accessible to residents. The inspector was able to access all medications and there were no staff within sight of the medication carts. Both doors to the medication room were left open and the back room door was also left open. When staff returned, they acknowledged that the doors should have been closed and locked prior leaving the medication room.
b) On March 15, 2012, at 1220 hours the medication cart was left unlocked, unattended, and accessible in the hallway by the nursing station on the first floor. Once staff returned to the cart they acknowledged that the cart was to be locked when unattended by staff.

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

s. 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). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 26(4)] Section 26(4)(a)(b) Previously issued as a WN February 7-11, 2011.
The Registered Dietitian did not assess risks related to an identified resident's weight and hydration status at the 2012 nutritional review. Nursing progress notes identify indications of fluid accumulation and the need for scheduled weight monitoring, however, the nutritional assessment completed by the Registered Dietitian did not include an assessment the resident's fluid status in relation to the significant weight gain and need for further weight monitoring.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 44]
The licensee did not ensure that sufficient enteral feeding devices were readily available at the home to meet the nursing and personal care needs of residents. An identified resident had a feeding pump malfunction and a back up pump was not available as a replacement. The resident required bolus feeding as a result of the equipment shortage, which placed the resident at increased risk for aspiration pneumonia. There were other residents at the home who required enteral feeding and a replacement pump was not available in the home for emergencies/equipment failure.

Issued on this 21st day of August, 2012

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

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
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
Mar 7, 8, 12, 15, Apr 17, 18, 19, 23, 24, Jun 5, 6, 7, 8, 11, 12, 21, 25, 26, 28, Jul 11, 12, 2012	2012_066107_0006 H-000571-12.	Follow Up

Licensee/Titulaire
HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

Long-Term Care Home/Foyer de soins de longue durée
HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

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

Inspection Summary/Sommaire d'inspection

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

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.5	CO	#001	2011_107_2776_01Feb145437, H-00224	107
LTCHA, 2007, S.O. 2007 c. 8, s.6(10)(b)(c)	CO	#002	2011_107_2776_01Feb145437, H-00224	107
O. Reg. 79/10, s.72(2)(g)	CO	#006	2011_107_2776_01Feb145437, H-00224	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. Z/ Wareman, RD
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Aug 21, 2012