Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 9, 2013	2013_191107_0003	H-002202-12	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

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

This inspection was conducted on the following date(s): January 25, 30, 31, February 1, 5, 6, 2013

During the course of the inspection, the inspector(s) spoke with residents, 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 and dietary staff on all floors

During the course of the inspection, the inspector(s) toured the home, reviewed identified resident's clinical health records, observed meal service in all dining areas, observed food production systems, and reviewed relevant policies and procedures

The following Inspection Protocols were used during this inspection:
Dining Observation

Food Quality

Nutrition and Hydration

Quality Improvement

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(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 WN, August 24, 2011 as VPC, March 7, 2012 as VPC
The plan of care for resident #01 did not set out clear direction for staff and others providing direct care to the resident.
a) The plan of care directed staff to provide "high energy high protein interventions", however, it did not provide clear direction on what high energy high protein interventions to provide. The home's policy related to high energy high protein dietary interventions also did not provide staff with direction on what to provide for each resident at meals.
b) The plan of care was reviewed on January 25, 2013 and it contained conflicting information related to where the resident ate their meals and the required diet texture. The "Eating" section of the plan of care identified the resident ate in one area and required a certain diet texture, however, the "Diet/Risk" section of the plan of care identified that the resident ate in a different location and required a different texture of diet. The Registered Dietitian confirmed that the two sections of the plan were conflicting and did not provide clear direction. [s. 6. (1) (c)]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The licensee did not ensure that the written plan of care for resident #03 provided clear direction to staff and others who provided direct care to the resident. The level of assistance required for eating was different in various sections of the plan of care. The "Eating" focused section of the plan stated the resident intermittently required total assistance but usually only encouragement, however, the "Nutrition" focused section stated the resident required total assistance with eating. During two observed meals the resident did not receive assistance with eating. Staff interviewed stated the resident did not require total assistance with eating. [s. 6. (1) (c)]

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The plan of care for resident #04 did not provide clear directions for staff and others who provided direct care to the resident in relation to the resident's diet.
a) The resident was re-admitted to the home after a significant change in status and the resident's diet was changed to a different texture and consistency of fluids. The resident's plan of care (as of January 30, 2013) directed staff to provide one consistency of fluids under the "Diet/Risk level" focused area of the plan and directed staff to provide a different consistency of fluids under the "Nutrition" focused area of the plan.
b) The plan of care directed staff to provide high energy high protein interventions,

however, it did not provide clear direction on what high energy high protein interventions to provide. The home's policy related to high energy high protein dietary interventions also did not provide staff with direction on what to provide for each resident at meals. [s. 6. (1) (c)]

4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The plan of care for resident #08 did not provide clear directions for staff and others providing care to the resident in relation to the resident's fluid restriction. Clear direction on how much fluid to offer at each meal was not provided to staff portioning meals. Nursing staff interviewed stated that the diet list indicated the quantity of fluids the resident was allotted for each meal, however, the diet list only indicated the total restriction for the day. During interview, the resident stated that staff controlled their fluid intake and that they just drank the beverages they were provided. At the supper meal January 30, 2013, the resident was offered approximately half their total fluid intake for the day and was documented as consuming more fluids than the restriction allowed on 12/30 days for the month of January 2013. [s. 6. (1) (c)]

5. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued as a CO on Feb 7, 2011, CO March 7, 2012
The licensee did not ensure that the care set out in the plan of care was provided to resident #03 as specified in their plan. The resident had a plan of care directing staff to provide thickened fluids to reduce the risk for choking. The resident was provided the incorrect consistency of thickened fluids at the lunch meal January 30, 2013. Staff confirmed the fluids were not the required consistency. [s. 6. (7)]

6. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The licensee did not ensure that the care set out in the plan of care was provided to resident #13 as specified in their plan at the observed lunch meal February 6, 2013. The resident had a plan of care that required thickened fluids, however, the resident was provided a different consistency than was required. [s. 6. (7)]

7. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for resident #04 was not provided to the resident as specified in their plan.
a) The plan of care stated the resident required high energy high protein dietary interventions, which the Registered Dietitian clarified would include high protein milk with meals. The resident's plan of care identified the resident preferred milk and

resident interview identified the resident was not offered milk at the lunch meals January 25, 31 and February 6, 2013.
b) The resident also required thickened fluids related to risk for aspiration, however, the resident received the incorrect consistency of thickened fluids at the lunch meal January 30, 2013. [s. 6. (7)]

8. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for resident #06 was not provided to the resident as specified in the plan. The resident had an order for a nutritional supplement to be provided if the resident refused meals or consumed less than 50% at meals. Food and fluid intake records were reviewed for one month and the resident required the supplement at eight meals that were taken poorly or refused. Staff interview confirmed that the resident was not provided the supplements when the resident ate poorly. The interventions were identified on the 3 month medication review signed by the physician and the Dietitian confirmed the supplement was not discontinued, however, the order was not identified on the home's computerized medication administration system (eMAR) and the supplement was not provided to the resident. [s. 6. (7)]

9. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for resident #09 was not provided to the resident as specified in the plan. The resident had an order for a nutritional supplement to be provided if the resident consumed less than 25% or refused meals. Food and fluid intake records were reviewed over a 10 day period and the resident required the supplement at eight meals that were refused. Staff interview confirmed that the resident was not provided the supplements when the resident ate poorly. The Dietitian confirmed the supplement was not discontinued, however, the order was not identified on the home's computerized medication administration system (eMAR) and the supplement was not provided to the resident. The resident had a significant unplanned weight loss. During interview, staff identified they were not aware that the resident required a supplement when they ate poorly. [s. 6. (7)]

10. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)] Previously issued February 7, 2011 as CO, March 7, 2012 as a VPC
Resident #04 was not reassessed and their plan of care reviewed and revised when the resident's care needs changed.
a) The resident had more than a 50% decline in their hydration after hospitalization without a re-assessment of their plan of care with interventions to address the poor

hydration. Documentation in the progress notes did not include any reference to poor hydration over a one month period.
b) The resident was re-assessed by the Registered Dietitian after one month of poor hydration and the resident's hydration target and diet texture was changed, however, the plan of care was not revised to reflect the changes. [s. 6. (10) (b)]

11. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(c)] Previously issued February 7, 2011 as CO, corrected March 7, 2012.
Resident #07 was not reassessed and their plan of care reviewed and revised when the care set out in the plan was not effective.
a) The resident had a plan of care that identified a specific fluid requirement, however, the resident did not meet their fluid requirement on any day since admission (almost one month). The resident was reviewed by the Registered Dietitian who identified the resident was not meeting their hydration requirement, however, the plan of care was not revised to address the poor hydration. A progress note a few days later identified that the resident had abnormal electrolytes and to push fluids to ensure the resident didn't get dehydrated, however, there was no documented follow up on the effectiveness of pushing fluids and the resident continued to have poor hydration until admitted to hospital. An assessment of the reasons for the poor hydration did not occur and action was not routinely taken by staff to address the poor hydration. Staff confirmed that a referral back to the Registered Dietitian was not completed and that action was not taken to address the poor hydration and the plan of care was not revised to include strategies to increase the resident's hydration (care plan referred only to hydration when the weather was hot). The resident had significant issues with skin integrity, fever, and high blood sugar, which would increase the resident's hydration requirement.
b) The resident had an order for protein powder with meals and high protein milk with meals. During interview the resident stated they did not like the protein powder and were not routinely taking it. Staff interview confirmed that resident had not been provided the protein powder at the breakfast meal February 5, 2013. The resident was not re-assessed in relation to the protein powder with revision of the plan of care based on the resident's refusal of the supplement. The resident required additional protein in relation to significant wound healing. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002, 010 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 s. 6(10)(c), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 8(1)(b)] Previously issued February 7, 2011 as a VPC, March 12, 2012 as a VPC
The home's "hypoglycemia protocol" related to hypoglycemia management was not followed by staff providing care to resident #05. The policy provided specific direction related to when to treat low blood sugars (< 4.0 mmol/L), the amount (15-20 grams) and type (several food options listed) of carbohydrate to provide when low blood sugar occurred, when to recheck the blood sugar to monitor the effectiveness of the interventions (15 minutes), and what to do if treatment was ineffective. The policy was not followed for 13/13 episodes of hypoglycemia documented over an 18 day period.
a) The resident was over-treated, treatment was not provided, incorrect treatment was provided, or follow up to ensure the blood sugar had returned to normal prior to the discontinuation of treatment did not occur. Staff confirmed that the policy was clear, however, not followed by staff providing care to the resident. [s. 8. (1)]

2. [O.Reg. 79/10, s. 8(1)(b)] Previously issued February 7, 2011 as a VPC, March 12, 2012 as a VPC
The licensee did not ensure that the home's "Weights 05-02-07A" policy was complied with by staff providing care to residents. At least four residents were not re-weighed to verify the accuracy of significant weight changes and resident weights were not always taken prior to the 7th of the month as specified in the policy. Staff confirmed that the weights were not always completed as required and within the time-frame specified in the policy. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 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. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (c) standardized recipes and production sheets for all menus; 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 O. Reg. 79/10, s. 72 (3).

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, (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(2)(c)] Previously issued as CO February 7, 2011, cleared March 7, 2012.
Standardized recipes and production sheets were not in place to direct staff in the consistent preparation of some menu items.
a) Recipes were not in place for the preparation of snacks (other than ready to serve items) and pureed snacks that required preparation by staff. The Nutrition Manager confirmed that recipes were not available for the snack menu and texture modified snacks.
b) The Nutrition Manager also confirmed that recipes for many of the texture modified vegetarian items were not in place.
c) Direction was not provided to staff on the quantity and type of fluids to add to the texture modified items to ensure a consistent and quality end product prepared by staff.
d) Recipes did not always reflect the actual items being prepared by staff. For example, the recipe for pureed cranberry glazed chicken directed staff to use a commercially prepared pureed chicken product, however, the home was preparing the chicken and not using a commercially prepared product. Adequate direction on how to prepare the chicken was not provided. A similar example with the pureed fish recipe directed staff to use a commercially prepared fish product that the home was not using.
e) The production sheet for the breakfast meal February 1, 2013 did not include direction for staff to prepare the alternative pureed bread and the item was not prepared and available as required on the therapeutic extension menu [s. 72. (2) (c)]

2. [O.Reg. 79/10, s. 72(3)(a)] Previously issued February 7, 2011 as a VPC, and March 7, 2012 as a VPC
Not all foods were prepared and served using methods that preserved taste, nutritive value, and food quality.
a) At the lunch meal January 30, 2013, the pureed bread was noted to be soupy and running from the spoon. Additional fluid was added to the bread, resulting in reduced nutritive value and flavour. The consistency of the bread was not suitable for residents requiring thickened fluids (too runny).
b) Appropriate sauces were not available or planned on the menu for providing moisture to the minced and pureed menus resulting in inappropriate liquids being added to foods. At the lunch meal January 25, 2013 brown gravy was served on the minced and pureed fish, however, a dill sauce was planned and provided for the regular textured fish. One resident who disliked gravy and required additional

moisture with meals received soup poured over their meal instead of including appropriate sauces on a planned menu for the identified resident. The appearance and taste of the meal was not maintained when brown gravy and soup were added to the minced and pureed fish.
c) Foods were prepared and hot held too far in advance of the supper meal service on February 5, 2013. During interview dietary staff stated that all foods were required to be placed into the hot holding carts by 1615 for the 1700 supper meal, however, the Nutrition Manager stated foods should not be placed into hot holding more than 1/2 hour in advance of the meal service. One example of foods prepared too far in-advance of meal service resulting in reduced quality, taste and nutritive value: Plain baked fish was already cooked when the inspector entered the kitchen at 1415 and was then placed into the oven for hot holding at 1455 for the supper meal. Pureed fish was prepared at the same time and was placed into hot holding and at 1550 the items were heated even more in the steamer. The fish was noted to be dry.
d) Staff serving cooked vegetables at the lunch meal January 25, 2013 did not use a utensil that allowed the water to escape and water was being scooped up and onto the plates, resulting in reduced quality and water running into other items [s. 72. (3) (a)]

3. [O.Reg. 79/10, s. 72(3)(b)]
Not all foods were stored using methods that prevented contamination and food borne illness. Items stored in the refrigerator on February 6, 2013 were not labeled and dated. Many of the items were for the next day breakfast meal, however, some items the cook identified to be past due and required discarding and leftovers from the day prior were not labeled or dated. [s. 72. (3) (b)]

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 foods are stored using methods that prevent contamination and food borne illness, s. 72(3)(b, and ensuring standardized recipes and production sheets are in place for all menus, s. 72(2) (c), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 73 (1).

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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

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:
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. O. Reg. 79/10, s. 73 (1).

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)1]
The daily and weekly menus were not communicated to residents receiving diets other than the regular menu. Items on several specialized menus varied from the regular menu, however, this was not communicated to residents. A resident voiced concerns about not knowing what was on the menu and not being aware what menu choices were available. Staff confirmed that a process was not currently in place to communicate the other menus to residents. [s. 73. (1) 1.]

2. [O.Reg. 79/10, s. 73(1)5] Previously issued March 7, 2012 as a VPC
A process was not in place to ensure that food service workers and other staff assisting residents were aware of the residents' current diets, special needs and preferences. Information on the dietary serving lists was not always current and did not consistently reflect the residents' current level of assistance required with eating and resident preferences.
Some examples:
a) Resident #13 - the diet list stated the resident required total assistance with eating, however, the resident ate independently and the resident's plan of care identified encouragement only.
b) Resident #02 - the diet list stated the resident did not require assistance with eating, however, the resident had a change in condition and now required total assistance with eating and was being assisted by staff.
c) Resident #16 - the diet list stated the resident disliked an item, however, during interview the resident stated that they enjoyed the item and had told staff to update the list months ago.
d) Resident #17 - the diet list stated the resident required only supervision/encouragement, however, the resident required total assistance by staff
e) Resident #18 - the diet list stated the resident required only supervision/encouragement, however, the resident required extensive assistance by staff
f) Resident #15 - the diet list stated the resident did not require assistance with eating, however, the resident's plan of care stated they required total assistance with eating
g) Resident #19 - the diet list stated the resident did not require assistance with eating, however, the resident required extensive assistance with eating
h) Resident #20 - the diet list stated the resident required total assistance with eating, however, the resident's plan of care stated variable assistance required and the resident was observed eating independently
i) Resident #21 - the diet list did not provide clear direction to staff serving food -

directed staff to provide a certain item at lunch and supper, however, also indicated the resident disliked the item [s. 73. (1) 5.]

3. [O.Reg. 73(1)9] Previously issued February 7, 2011 as a CO, March 7, 2012 as a CO
Not all residents were provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible at meals.
a) At the lunch meal January 25, 2013 resident #27 was not assisted with eating and ate poorly. The resident had a plan of care requiring total assistance with eating and the dietary serving list also indicated the resident required total assistance with eating. Staff stated the resident sometimes wouldn't allow staff to assist with eating, however, staff had not approached the resident or offered assistance with the meal until the meal service was finished. The resident was verbally encouraged, however, that was unsuccessful. The resident was not offered total assistance or physical assistance with eating. [s. 73. (1) 9.]

4. [O.Reg. 79/10, s. 73(1)10] Previously issued February 7, 2011 as a CO, March 7, 2012 as a CO
Proper feeding techniques were not used to assist residents with eating at meals.
a) Resident #23 was being fed in a chair that was tilted backwards with the resident's chin un-tucked, creating a risk for choking. Staff did not correct the positioning until the Inspector went to the table at the lunch meal February 5, 2013.
b) Three residents (#24, 18, 25) had their mouths scraped with the spoon while being assisted with eating at the breakfast meal February 1, and supper meal January 30, 2013.
c) Two residents (#25, #26) had their pureed food mixed together at the meal by staff assisting the residents. The residents were unable to voice their preferences. Staff interviewed stated one of the residents didn't like the vegetables so they were mixed together so they would eat them. [s. 73. (1) 10.]

5. [O.Reg. 79/10, s. 73(2)(b)]
Meals were served prior to staff being available to provide assistance to residents at the lunch meals January 25 and 30, and supper meal January 30, 2013. Nine residents sat in-front of their meals for more than 5 minutes prior to assistance being provided.
Beverages were also placed on tables prior to assistance being available. Resident

#28, who required total assistance with eating, spilled their beverages on the floor while trying to reach them when assistance was not available and the beverages were on the table in-front of the resident. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 005, 006, 009 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 residents are provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible at meals, 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 February 7, 2011 as a CO, March 7, 2012 as a CO
Not all hazardous substances were kept inaccessible to residents at all times. A tub room was left unlocked and unattended at 11:30a.m. Arjo disinfectant (hazardous and poisonous) was accessible in the tub room. The inspector entered the room at 11:30 a.m and staff came at 11:35 a.m to obtain supplies for a resident. The staff member then left the tub room again and the door was left unlocked. The inspector questioned the PSW about the unlocked door and it was identified that door was supposed to lock automatically behind the staff. The PSW and Inspector tried the door 3-4 times and the door did not lock on any of these occasions. The problem was reported to the Administrator and the door to the tub room was pulled shut and secured. [s. 91.]

Additional Required Actions:

CO # - 007 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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

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(1)(e)]
The menu cycle was not approved by a registered dietitian who was a member of the staff of the home. Staff confirmed that the menu had been approved, however, it was approved by a registered dietitian who was not a member of the staff of the home. [s. 71. (1) (e)]

2. [O. Reg. 79/10, s. 71(4)] Previously issued March 7, 2012 as a VPC
Not all residents were offered planned menu items at each meal.
a) Not all residents were offered the planned portion size of menu items. Portions offered at meals were not consistent with the planned portion sizes identified on the therapeutic extension menus. Some examples:
At the 2nd floor supper meal January 30, 2013, ten of the items were served using the incorrect size portion - #6 scoop required for pureed lentil casserole, #8 scoop served (smaller); 6oz portion required for regular lentil casserole, 3oz portion served; #12 scoop required for minced vegetables, and minced and pureed pears, #8 scoop served (larger); #12 scoop required for pureed bread, #10 scoop served (larger); #12 scoop required for minced salad, #10 scoop served (larger); #8 scoop required for caramel pudding, #12 scoop served (smaller). The planned menu identified serving the pureed meat and pureed bread separately for the pureed beef salad sandwich, however, the bread and meat were combined, resulted in reduced nutritional value when only 1 small scoop was used for the combined product. At the 3rd floor lunch meal January 25, 2013, 5 meatballs were served instead of the planned 6 meatballs, resulting in reduced nutritional value of the meal.
b) Not all items served to residents matched the planned menu. The planned menu identified a veggie patty for the supper meal January 30, 2013, however, a vegetarian luncheon meat sandwich was served.
c) Not all items listed on the planned menu were offered to residents at meals.
i) Regular and pureed bread were identified on the planned menu, however, bread was not offered to residents at the lunch meal January 25, 2013
ii) Bread was not offered for the minced and pureed menus at the lunch meal on February 5, 2013
iii) Most residents requiring a pureed menu were served mashed potatoes (different food group) instead of pureed bread which was on the planned menu at the supper meal January 30, 2013 (only served bread when ran out of mashed potatoes).
d) Not all residents were offered milk or thickened milk, as per the planned menu at the lunch meals January 25 lunch, January 30 lunch, and January 31 lunch, breakfast meal February 5, 2013. Some examples:

i) Resident #04 was not offered milk at two observed meal services despite having a plan of care that indicated the resident preferred milk and required a high energy high protein menu.
ii) Resident # 22 was not offered milk. Interview with their family member who consistently assisted the resident indicated the resident was frequently not offered milk with meals and they were not sure why.
iii) Resident #07 was not offered milk with their meal at the breakfast meal despite requiring a high energy high protein menu. [s. 71. (4)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 68(2)(d)]
Staff did not monitor and evaluate the food and fluid intake of resident #04, who was at nutrition risk. Monitoring records contained conflicting data, which prevented clear evaluation of the information. Documentation in the progress notes related to fluid consumption was not consistent with documentation in the Point of Care (POC) system. Progress notes stated, "took fluids well" or "full intake of fluids at supper", however, actual fluid intake recorded in the POC system stated 125ml or 180ml for the meals, which would not be the full amount of fluids offered on the planned menu for meals. The information was inconsistent and problems with poor hydration were not monitored and evaluated by staff. [s. 68. (2) (d)]

2. [O.Reg. 79/10, s. 68(2)(e)] (Previously issued February 2012 as VPC under s. 8(1) (b) related to not following the weight policy)
A weight monitoring system was not in place to ensure that Resident #02 had their weight, height, and body mass index measured on admission. The resident did not have their weight, height or body mass index measured and recorded 14 days after admission, at the time the resident's clinical record was reviewed. Staff confirmed that the information was required for this resident and that the resident's height, weight, and body mass index was not measured on admission. [s. 68. (2) (e)]

3. [O.Reg. 79/10, s. 68(2)(e)(i)]
Resident #009 did not have their weight measured and recorded for one month. A weight was not recorded in the computer, the bath record sheet, the re-weight sheets, nor in the progress notes. The resident had a 10.6% significant weight loss over three months with no weight recorded for two of the three months during that three month period. [s. 68. (2) (e) (i)]

4. [O.Reg. 79/10, s. 68(2)(e)(i)]
The licensee did not ensure that resident #11 had their weight measured and recorded at least monthly. The resident did not have their weight recorded for one month. The resident was in hospital for an eleven day period at the beginning of the month. The resident's weight was not taken or recorded upon return from hospital and interview and documentation did not include rationale as to why the resident's weight was not taken and recorded. Staff confirmed the resident's weight was required to be taken upon return from hospital. The resident had new and multiple areas of skin breakdown upon return from hospital. [s. 68. (2) (e) (i)]

Additional Required Actions:

CO # - 011 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 a system is in place to monitor and evaluate the food and fluid intake of residents at nutritional risk, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

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1. [O.Reg. 79/10, s. 30(1)1]
The licensee of the home did not ensure that the dietary services and hydration program included methods to monitor outcomes of the "high energy high protein protocol policy". The policy identified strategies the home might use to provide residents with increased energy and protein, however, it did not identify the strategies the home actually used to provide residents with increased energy and protein and a measure of how much additional energy and protein were provided by the protocol to ensure the interventions could be evaluated for effectiveness. Identified residents with a physician/Registered Dietitian order for high energy high protein protocol interventions were observed not receiving interventions that were ordered and staff confirmed they were not provided (residents #03,04,07,09). A system was not in place to document high protein milk, protein powder, nutritional supplements provided at snacks or for meal replacement, for residents #01,03,04,06,07,09,14 and staff confirmed that an evaluation of the effectiveness of the interventions was not possible as there would not be a way to know if the residents received the items.
Some specific examples:
a) Resident #09 had an order for a nutritional supplement to be provided if the resident consumed less than 25% of the meal or refused a meal. The resident refused eight meals over a 10 day period, however, it was unclear from the documentation if the resident was receiving/consuming the supplement. Staff interview identified that the supplement was not being provided as ordered and was not in the computerized medication system. Staff also confirmed that the supplement had not been discontinued. The resident had an unplanned significant weight loss noted the month the resident did not receive the required supplement.
b)Resident #06 had an order for a nutritional supplement at snack pass, however, review of the food and fluid intake records over one month did not indicate that the resident was offered or refused the nutritional supplement. Staff interview confirmed that staff could not determine from the current system if the resident consumed the supplement or a different type of fluid at the snack pass and if the supplement was ever refused by the resident. The Registered Dietitian confirmed that an evaluation of the effectiveness of the nutrition intervention could not be measured with the current system.
c) Resident #14 had an order for a nutritional supplement to be provided at snack pass. Staff confirmed that nutritional supplements provided at meals were documented as fluids and when looking at the documentation it was not possible to determine if the fluids recorded were supplements or regular fluids, resulting in the inability to evaluate the effectiveness of the intervention.

d) Resident #04 had a physician/Registered Dietitian order for high energy high protein protocol interventions, was observed at three meals and did not receive the interventions that the Dietitian indicated they would receive (high protein milk), however, there was no system to document that the resident did not receive the required items. Documentation in the progress notes did not indicate that the resident did not receive the required item and staff interview confirmed there would not be a way to know if the resident received the item.
e)Documentation for resident #07 did not include high protein high energy interventions, resulting in the inability to evaluate the effectiveness of the interventions. The resident was not offered the ordered protein powder and was frequently refusing it (as per resident interview), however, the resident's response to the intervention was not documented and communicated to the Registered Dietitian.
f)Resident #03 had a plan of care that required protein powder to be provided at each meal, however, staff did not document when the protein powder was provided or if it was consumed. Interview with the Registered Dietitian confirmed that an evaluation of the resident's response to the protein powder was difficult as it was not always clear if the resident was being offered the protein powder or if the protein powder was being consumed. [s. 30. (1) 1.]

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 dietary services and hydration program includes methods to monitor outcomes of the high energy high protein protocol policy, s. 30(1)1, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 101(4)]
The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and any significant change in resident's condition, either decline or improvement, to be reassessed along with RAPs by the interdisciplinary care team using the MDS Full assessment by the 14th day following the determination that a significant change in status had occurred.

The licensee did not comply with the conditions to which the license is subject for the following identified residents:
a) Resident #04 had a significant change in status (decline), however, the RAI-MDS assessment and 9/13 triggered RAPs were incomplete more than one month after the change was identified. The RAP that was most related to the change in status had not been completed.
b) Resident #07 had a re-admission RAI-MDS assessment initiated (was also a change in status), however, the assessment remained incomplete almost one month later.
c) Resident #08 had a quarterly review initiated, however, the nursing RAPs had not been completed 41 days after the review was started.
d) Management confirmed that many of the nursing department RAI-MDS assessments were not completed according to the scheduled dates and that staff were behind in the assessments. [s. 101. (4)]

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 licensee complies with conditions to which the license is subject, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 24(1)]
The licensee did not ensure that a 24 hour admission care plan was developed for resident #02 within 24 hours of the resident's admission to the home. Registered and front line nursing staff confirmed that a 24 hour admission care plan was not developed and in place for this resident 14 days later. It was later observed that a plan of care was developed the day after the resident was discharged from the home. [s. 24. (1)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 69.	CO #003	2012_066107_0006	107
O.Reg 79/10 s. 72. (2)	CO #004	2012_066107_0006	107
LTCHA, 2007 S.O. 2007, c.8 s. 84.	CO #002	2012_066107_0006	107

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 21st day of May, 2013

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

Michelle Warrener, RD

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2013_191107_0003
Log No. / Registre no:	H-002202-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 9, 2013
Licensee / Titulaire de permis :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
LTC Home / Foyer de SLD :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ROSEMARY OKIMI

To HERITAGE GREEN NURSING HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must prepare, submit and implement a plan that ensures that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to residents in relation to fluid restrictions, high energy high protein nutrition interventions, diet texture/fluid consistency, level of assistance required with eating, and between different areas of the nutrition related sections on the plan of care.
The plan is to be submitted by May 23, 2013 to Long Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1.

[LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The plan of care for resident #08 did not provide clear directions for staff and others providing care to the resident in relation to the resident's fluid restriction. Clear direction on how much fluid to offer at each meal was not provided to staff portioning meals. Nursing staff interviewed stated that the diet list indicated the quantity of fluids the resident was allotted for each meal, however, the diet list only indicated the total restriction for the day. During interview, the resident stated that staff controlled their fluid intake and that they just drank the beverages they were provided. At the supper meal January 30, 2013, the resident was offered approximately half their total fluid intake for the day and was documented as consuming more fluids than the restriction allowed on 12/30

days for the month of January 2013. [s. 6. (1) (c)] (107)

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The plan of care for resident #04 did not provide clear directions for staff and others who provided direct care to the resident in relation to the resident's diet.
a) The resident was re-admitted to the home after a significant change in status and the resident's diet was changed to a different texture and consistency of fluids. The resident's plan of care (as of January 30, 2013) directed staff to provide one consistency of fluids under the "Diet/Risk level" focused area of the plan and directed staff to provide a different consistency of fluids under the "Nutrition" focused area of the plan.
b) The plan of care directed staff to provide high energy high protein interventions, however, it did not provide clear direction on what high energy high protein interventions to provide. The home's policy related to high energy high protein dietary interventions also did not provide staff with direction on what to provide for each resident at meals. (107)

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The licensee did not ensure that the written plan of care for resident #03 provided clear direction to staff and others who provided direct care to the resident. The level of assistance required for eating was different in various sections of the plan of care. The "Eating" focused section of the plan stated the resident intermittently required total assistance but usually only encouragement, however, the "Nutrition" focused section stated the resident required total assistance with eating. During two observed meals the resident did not receive assistance with eating. Staff interviewed stated the resident did not require total assistance with eating. (107)

4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]Previously issued November 17, 2010 as WN, August 24, 2011 as VPC, March 7, 2012 as VPC
The plan of care for resident #01 did not set out clear direction for staff and others providing direct care to the resident.
a) The plan of care directed staff to provide "high energy high protein interventions", however, it did not provide clear direction on what high energy high protein interventions to provide. The home's policy related to high energy high protein dietary interventions also did not provide staff with direction on what to provide for each resident at meals.
b) The plan of care was reviewed on January 25, 2013 and it contained

conflicting information related to where the resident ate their meals and the required diet texture. The "Eating" section of the plan of care identified the resident ate in one area and required a certain diet texture, however, the "Diet/Risk" section of the plan of care identified that the resident ate in a different location and required a different texture of diet. The Registered Dietitian confirmed that the two sections of the plan were conflicting and did not provide clear direction. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2012_066107_0006, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to residents, including residents #04, 04, 06, 09, 13, as specified in their plans in relation to the provision of fluid consistency, nutritional supplements, and high energy high protein interventions.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for resident #09 was not provided to the resident as specified in the plan. The resident had an order for a nutritional supplement to be provided if the resident consumed less than 25% or refused meals. Food and fluid intake records were reviewed over a 10 day period and the resident required the supplement at eight meals that were refused. Staff interview confirmed that the resident was not provided the supplements when the resident ate poorly. The Dietitian confirmed the supplement was not discontinued, however, the order was not identified on the home's computerized medication administration system (eMAR) and the supplement was not provided to the resident. The resident had a significant unplanned weight loss. During interview, staff identified they were not aware that the resident required a supplement when they ate poorly. (107)

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for resident #06 was not provided to the resident as specified in the plan. The resident had an order for a nutritional supplement to be provided if the resident refused or consumed less than 50% at meals. Food and fluid intake records were reviewed for one month and the

resident required the supplement at eight meals that were taken poorly or refused. Staff interview confirmed that the resident was not provided the supplements when the resident ate poorly. The interventions were identified on the 3 month medication review signed by the physician and the Dietitian confirmed the supplement was not discontinued, however, the order was not identified on the home's computerized medication administration system (eMAR) and the supplement was not provided to the resident. [s. 6. (7)]

(107)

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for resident #04 was not provided to the resident as specified in their plan.
a) The plan of care stated the resident required high energy high protein dietary interventions, which the Registered Dietitian clarified would include high protein milk with meals. The resident's plan of care identified the resident preferred milk and resident interview identified the resident was not offered milk at the lunch meals January 25, 31 and February 6, 2013.
b) The resident also required thickened fluids related to risk for aspiration, however, the resident received the incorrect consistency of thickened fluids at the lunch meal January 30, 2013. (107)

4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The licensee did not ensure that the care set out in the plan of care was provided to resident #13 as specified in their plan at the observed lunch meal February 6, 2013. The resident had a plan of care that required thickened fluids, however, the resident was provided a different consistency than was required. (107)

5. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued as a CO on Feb 7, 2011, CO March 7, 2012
The licensee did not ensure that the care set out in the plan of care was provided to resident #03 as specified in their plan. The resident had a plan of care directing staff to provide thickened fluids to reduce the risk for choking. The resident was provided the incorrect consistency of thickened fluids at the lunch meal January 30, 2013. Staff confirmed the fluids were not the required consistency. (107)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that staff comply with the home's "hyopglycemia management" protocol and "Weights" policies.
The plan should include:
a) an assessment of the current systems
b) staff education provided, including the dates of the education and which staff the education is targeted to (e.g. PSW's, Registered staff)
c) quality management activities (including the type of monitoring and frequency of monitoring) that will be implemented to target the identified area of non-compliance.
The plan is to be submitted by May 23, 2013 to Long Term Care Homes Inspector: Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 8(1)(b)] Previously issued February 7, 2011 as a VPC, March 7, 2012 as a VPC
The home's "hypoglycemia protocol" related to hypoglycemia management was not followed by staff providing care to resident #05. The policy provides specific direction related to when to treat low blood sugars (< 4.0 mmol/L), the amount (15-20 grams) and type (several food options listed) of carbohydrate to provide when low blood sugar occurs, when to recheck the blood sugar to monitor the effectiveness of the interventions (15 minutes), and what to do if treatment was ineffective. The policy was not followed for 13/13 episodes of hypoglycemia documented over a two month period.
a) The resident was over-treated, treatment was not provided, incorrect treatment was provided, or follow up to ensure the blood sugar had returned to normal prior to the discontinuation of treatment did not occur.
Staff confirmed that the policy was clear, however, not followed by staff providing care to the resident. (107)

2. [O.Reg. 79/10, s. 8(1)(b)] Previously issued February 7, 2011 as a VPC, March 7, 2012 as a VPC
The licensee did not ensure that the home's "Weights 05-02-07A" policy was complied with by staff providing care to residents. Several residents were not re -weighed to verify the accuracy of significant weight changes and resident weights were not always taken prior to the 7th of the month as specified in the policy. Staff confirmed that the weights were not always completed as required and within the time frame specified in the policy. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must prepare, submit, and implement a plan that outlines how the home will ensure that:
a) foods are not prepared and hot held too far in advance of meal service
b) the same level of quality is provided for items being prepared for the minced and pureed textured menus
c) recipes are followed in the preparation of menu items, including pureed bread, to ensure consistency of texture, nutrient density and flavour
d) the menu is reviewed to ensure an appropriate sauce is available for texture modified menus
d) appropriate utensils are available for meal service to ensure quality of the items is preserved
The plan is to be submitted by May 23, 2013 to Long Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 72(3)(a)] Previously issued February 7, 2011 as a VPC, and March 7, 2012 as a VPC
Not all foods were prepared and served using methods that preserved taste, nutritive value, and food quality.
a) At the lunch meal January 30, 2013, the pureed bread was noted to be soupy and running from the spoon. Additional fluid was added to the bread, resulting in reduced nutritive value and flavour. The consistency of the bread was not suitable for residents requiring thickened fluids (too runny).
b) Appropriate sauces were not available or planned on the menu for providing moisture to the minced and pureed menus resulting in inappropriate liquids being added to foods. At the lunch meal January 25, 2013 brown gravy was served on the minced and pureed fish, however, a dill sauce was planned and provided for the regular textured fish. One resident who disliked gravy and required additional moisture with meals received an inappropriate sauce poured over their meal instead of including appropriate sauces on a planned menu for the identified resident. The appearance and taste of the meal was not maintained when brown gravy and soup were added to the minced and pureed fish.
c) Foods were prepared and hot held too far in advance of the supper meal service on February 5, 2013. During interview dietary staff stated that all foods were required to be placed into the hot holding carts by 1615 for the 1700 supper meal, however, the Nutrition Manager stated foods should not be placed into hot holding more than 1/2 hour in advance of the meal service. One example of foods prepared too far in-advance of meal service resulting in reduced quality, taste and nutritive value: Plain baked fish was already cooked when the inspector entered the kitchen at 1415 and was then placed into the oven for hot holding at 1455 for the supper meal. Pureed fish was prepared at the same time and was placed into hot holding and at 1550 the items were heated even more in the steamer. The fish was noted to be dry.
d) Staff serving cooked vegetables at the lunch meal January 25, 2013 did not use a utensil that allowed the water to escape and water was being scooped up and onto the plates, resulting in reduced quality with water running into other items on the plate. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must prepare, submit and implement a plan that outlines how the home will ensure that food service workers and other staff assisting residents are aware of the residents' current diets, special needs and preferences. The plan is to be submitted to Long-Term Care Homes Inspector Michelle Warrener by May 23, 2013 at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 73(1)5] Previously issued March 7, 2012 as a VPC
A process was not in place to ensure that food service workers and other staff assisting residents were aware of the residents' current diets, special needs and preferences. Information on the dietary serving lists was not always current and did not consistently reflect the residents' current level of assistance required with eating and resident preferences.
Some examples:
a) Resident #13 - the diet list stated the resident required total assistance with eating, however, the resident ate independently and the resident's plan of care identified encouragement only.
b) Resident #02 - the diet list stated the resident did not require assistance with eating, however, the resident had a change in condition and now required total assistance with eating and was being assisted by staff.
c) Resident #16 - the diet list stated the resident disliked an item, however, during interview the resident stated that they enjoyed the item and had told staff to update the list months ago.
d) Resident #17 - the diet list stated the resident required only supervision/encouragement, however, the resident required total assistance by staff
e) Resident #18 - the diet list stated the resident required only supervision/encouragement, however, the resident required extensive assistance by staff
f) Resident #15 - the diet list stated the resident did not require assistance with eating, however, the resident's plan of care stated they required total assistance with eating
g) Resident #19 - the diet list stated the resident did not require assistance with eating, however, the resident required extensive assistance with eating
h) Resident #20 - the diet list stated the resident required total assistance with eating, however, the resident's plan of care stated variable assistance required and the resident was observed eating independently
i) Resident #21 - the diet list did not provide clear direction to staff serving food - directed staff to provide a certain item at lunch and supper, however, also indicated the resident disliked the item
(107)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013

Order # /
Ordre no : 006

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

Linked to Existing Order /
Lien vers ordre existant: 2012_066107_0006, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

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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).

Order / Ordre :