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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 8, 2015	2015_380593_0023	015648-15	Follow up

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

NORTHWOOD LODGE
51 Highway 105 P.O. Box 420 RED LAKE ON P0V 2M0

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 1 - 4, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager, Registered Nursing Staff, Registered Dietitian, Dietary Staff, Activation Staff, Housekeeping Staff, Personal Support Workers (PSW), residents and family members.

The inspector also observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **0 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #004	2015_246196_0007	593
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #010	2015_246196_0007	593
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #005	2015_246196_0007	593
LTCHA, 2007 S.O. 2007, c.8 s. 71. (1)	CO #009	2015_246196_0007	593

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:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for residents #002, #005, #007, #008 and #009 that sets out clear directions to staff and others who provided direct care for the residents.

A review of resident #002's current care plan found that texture modified fluids were required related to associated risks. This was also confirmed in a nutrition assessment completed for resident #002 which documented that the resident was to receive texture modified fluids. A review of the kitchen diet roster found that it was documented that the resident required a different consistency of texture modified fluids. A review of the nourishment cart diet roster found that it was documented that the resident required a different consistency of texture modified fluids.

During an interview with Inspector #593 September 2, 2015, the home's Registered Dietitian (RD) reported that resident #002 was to receive a specific type of texture modified fluids, they added that this resident was recently assessed by the Speech Language Pathologist (SLP) and the order for texture modified fluids was continued.

A review of resident #004's current care plan found that a specific consistency of texture modified fluids was required related to associated risks. A review of the nourishment cart diet roster found that the resident required texture modified fluids but it was not specified at which consistency. A review of resident #004's health care record found an order from

the home's RD of an oral nutrition supplement at a specific fluid consistency.

During an interview with Inspector #593 September 1, 2015, #S-106 reported that resident #004 required a specific fluid conssitency and currently they were feeding resident #004 a different consistency of texture modified fluids.

A review of resident #005's current care plan found a specific fluid consistency required related to associated risks. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific fluid consistency.

A review of resident #007's current care plan found a specific diet texture requirement. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific diet texture.

A review of resident #008's current care plan found a specific fluid consistency required related to associated risks. A review of the kitchen diet roster found no mention of the resident requiring a specific fluid consistency. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific fluid consistency.

A review of resident #009's current care plan found a specific fluid consistency required related to associated risks however there was also a documented note stating "email request from DOC to change to different fluid consistency". A review of the nourishment cart diet roster found that the resident was required to receive a different fluid consistency. A review of the kitchen diet roster found that the resident was required to receive a specific fluid consistency as in the care plan. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care for resident #001.

A review of resident #001's current care plan found interventions for a skin alteration including apply ointment/medications as ordered and cleanse with appropriate solutions and apply dressings as ordered.

A review of resident #001's health care record found a letter from the home's skin and wound care Registered Nurse in the Extended Class (RNEC) dated April, 2015, documenting the following: Swab altered skin for testing. Please irrigate altered skin with a specific solution daily cover with specific dressing. A handwritten note from the RNEC

was added to this- "x 7d (for seven days) then reswab". When a specific treatment arrives start using with specific skin dressing.

A review of resident #001's September 2015 Treatment Administration Record (TAR) found treatment needed including: Skin assessment to altered skin area every two weeks on bath days and dressing to altered skin, see new orders, every three days and on bath day and PRN (as necessary).

During an interview with Inspector #593, the Administrator reported the home's skin and wound care RNEC left the clinic and therefore they do not have access to this service anymore. The Administrator reported that there should be an order for this resident related to their skin treatment, a copy of this order should be in the TAR binder. They reported that usually the skin and wound care RNEC would send through an order after the skin assessment was completed however this may have been missed due to them leaving the clinic. If the physician assessed a resident's wound, the registered nursing staff should be documenting this in the home's electronic documentation system (Goldcare) after the assessment had been completed.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (1) (c) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The licensee has failed to ensure the care set out in the plan of care is provided to four residents as specified in the plan, specifically related to the provision of a texture modified diet.

Inspector #593 observed posted on the wall in the kitchen, a large photograph of a plate of ground meat. Written on the photograph was "please let the Administrator know if the minced does not look like this".

During an interview with Inspector #593 on September 3, 2015, the Team Lead of food services reported that toast is provided for residents requiring a minced diet and the crusts should be cut off and the toast should be cut into pieces for the residents.

During an interview with Inspector #593 on September 2, 2015, the home's Registered Dietitian (RD) reported that the hospital needed to mince the food properly and that the

expectation is that the minced food resembles ground beef. The RD added that all residents should be receiving the same texture if they are on a minced diet.

A review of the dining room diet roster found four residents were to receive a minced textured diet with "minced all" being documented. This was confirmed in the resident's plan of care.

On September 1, 2015, during the lunch meal service, Inspector #593 observed the following:

• One of the residents requiring a minced diet was provided a sandwich with sliced meat and salad, the crusts were left on and the sandwich was not cut up. The filling of the sandwich was not minced. The salad provided was not minced.

• One of the residents requiring a minced diet was provided a cut up toasted sandwich, the crusts were left on the bread. Later during the meal service, the resident was provided a second meal which was a sandwich and bean salad. This was not minced.

• One of the residents requiring a minced diet was provided a salmon sandwich, the crusts were left on and the sandwich was not cut up. There was a finely chopped salad served next to the sandwiches however this was not minced texture.

On September 2, 2015, during the breakfast meal service, Inspector #593 observed the following:

• One of the residents requiring a minced diet was provided toast with jam, the toast was not cut up nor were the crusts removed.

• One of the residents requiring a minced diet was provided two slices of toast sandwiched together, the crusts were cut off however the toast was not cut up.

• One of the residents requiring a minced diet was provided toast with jam, the crusts were cut off however the toast was not cut up.

• One of the residents requiring a minced diet was provided toast with jam, the crusts were cut off and the toast was cut up. [s. 6. (7)]

4. The licensee has failed to ensure the care set out in the plan of care was provided to

resident #001 as specified in the plan, specifically related to the provision of oral nutrition supplements.

A review of resident #001's current care plan found that the resident was to receive a specific oral nutrition supplement at the PM snack. A review of the nourishment cart diet roster also documented this nutrition intervention.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart pass resident #001's room on two occasions. Multiple oral nutrition supplements were observed to be available on the cart. The resident was observed to be in their room at the time; however the resident was not offered or provided an oral nutrition supplement from the cart. [s. 6. (7)]

5. The licensee has failed to ensure the care set out in the plan of care was provided to resident #004 as specified in the plan, specifically related to the provision of oral nutrition supplements.

A review of resident #004's current care plan found that the resident was to receive a specific oral nutrition supplement at the PM snack. A review of the nourishment cart diet roster also documented this nutrition intervention.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart enter the common living area of the home. Multiple oral nutrition supplements were observed to be available on the cart. Resident #004 was seated in this area however they were not offered or provided an oral nutrition supplement at the time. The PSW was then observed to take the nourishment cart back to the kitchen.

During an interview with Inspector #593 September 2, 2015, the home's Registered Dietitian reported that resident #004 is required to receive a specific oral nutrition supplement at PM and HS snack.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (7) Every licensee of a long-term care home shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with food and fluids that are safe.

Inspector #593 observed, a large photograph of a plate of ground meat posted on the wall in the kitchen. Written on the photograph was "please let the Administrator know if the minced does not look like this".

During an interview with the inspector on September 3, 2015, the Team Lead of food services reported that toast is to be provided for residents requiring a minced diet and the crusts are to be cut off. In addition the toast should be cut into pieces for the residents.

During an interview with the inspector on September 2, 2015, the home's Registered Dietitian (RD) reported that the hospital are required to mince the food properly and that the expectation is that the minced food resembles ground beef. The RD added that all residents should be receiving the same texture if they are on a minced diet.

A review of the dining room diet roster found that four residents were to receive a minced textured diet with "minced all" being documented. This was also documented in the resident's plan of care.

On September 1, 2015, during the lunch meal service, Inspector #593 observed the following:

• One of the residents requiring a minced diet was provided a sandwich with sliced meat and salad, the crusts were left on the bread and the sandwich was not cut up. The filling of the sandwich was not minced. The salad provided was not minced.

• One of the residents requiring a minced diet was provided a cut up toasted sandwich, the crusts were left on the bread. Later during the meal service, the resident was provided a second meal which was a sandwich and bean salad. This was not minced.

• One of the residents requiring a minced diet was provided a salmon sandwich, the crusts were left on the bread and the sandwich was not cut up. There was a finely chopped salad served next to the sandwiches however this was not minced texture.

On September 2, 2015, during the breakfast meal service, Inspector #593 observed the following:

• One of the residents requiring a minced diet was provided toast with jam, the toast was not cut up nor were the crusts removed from the bread.

• One of the residents requiring a minced diet was provided two slices of toast sandwiched together, the crusts were cut off the bread however the toast was not cut up.

• One of the residents requiring a minced diet was provided toast with jam, the crusts on the bread were cut off however the toast was not cutup.

• One of the residents requiring a minced diet was provided toast with jam, the crusts on the bread were cut off and the toast was cut up.

On September 1, 2015, during the PM nourishment pass, the inspector observed the nourishment cart delivered to the nurses' station from the kitchen at 1440h. Resident #002's oral nutrition supplement was observed to be on the cart at this time. This was not served to the resident until 50 minutes later, in which the oral nutrition supplement was observed to be thin consistency.

A review of resident #002's current care plan found that the resident was required to have a specific fluid consistency related to associated risks.

During an interview with Inspector #593 September 2, 2015, the home's Registered

Dietitian (RD) reported that the oral nutrition supplement is a special recipe for resident #002 and it should be taken out of the freezer only 15 minutes before serving to the resident. This was to ensure that the resident received the supplement at the correct consistency.

On September 1, 2015, during the PM nourishment pass, the inspector observed resident #004 being provided a texture modified beverage. #S-106 was observed to be assisting them with their beverage. It was observed that the only thickened fluid available on the nourishment cart was commercially prepared texture modified apple juice at a specific consistency.

During an interview with Inspector on #593 September 1, 2015, #S-106 reported that they were feeding resident #004 a texture modified beverage at a specific consistency as that is what was available to them on the nourishment cart.

On September 2, 2015, during the AM nourishment pass, the inspector observed resident #004 being provided a texture modified beverage. #S-107 was observed to be assisting them with their beverage and the resident coughed several times while being fed. It was observed that the only thickened fluid available on the nourishment cart was commercially prepared texture modified apple juice at a specific consistency which was different to what was specified in the resident's care plan.

A review of resident #004's current care plan found that the resident required texture modified fluids related to associated risks. A review of the nourishment cart diet roster found that the resident required the same texture modified fluids.

During an interview with Inspector #593 September 2, 2015, #S-107 reported that for all nourishment passes, they use the pre-thickened juices for all residents requiring thickened fluids. #S-107 indicated that the texture modified apple juice in a specific consistency was what they use for all residents requiring texture modified fluids during the nourishment pass. They added that they will specially prepare texture modified fluids for meals but not for the nourishment passes.

On September 1, 2015, Inspector #593 observed during the lunch meal service, a variety of texture modified fluids that were prepared by the dietary staff. There were three fluids prepared and served to residents #001, #002 and #004 and each of these fluids was observed to be a different consistencies.

On September 2, 2015, Inspector #593 observed #S-103 preparing texture modified fluids for the dinner meal service. During an interview with Inspector #593 on September 2, 2015, #S-103 reported that resident #004 was to receive a specific type of texture modified fluids however the remainder that required texture modified fluids were to receive a different consistency. They added that there were a few residents that required a third consistency of texture modified fluids however the staff would modify the beverage at the point of service if the resident required the fluids to be a different consistency.

On September 2, 2015, during the dinner meal service, the inspector observed resident #004 being served a texture modified meal of beef and vegetables. The texture modified beef and vegetables was observed to be thin consistency.

A review of resident #004's current care plan found that the resident required a specific consistency of texture modified foods. This was also documented on the dining room/kitchen diet roster and confirmed during an interview with the home's RD on September 2, 2015.

On September 3, 2015, Inspector #593 observed during the breakfast meal service, a selection of beverages that had been thickened by staff for resident's #001, #002 and #004. One of the beverages provided to resident #001 was observed to be regular consistency. Two of the beverages that were provided to resident #002 included a milk based drink that was regular consistency and an orange juice that was a texture modified consistency. Two of the beverages that were provided to resident #004 included a prune juice that was texture modified and a coffee that was a different consistency than the prune juice.

A review of resident #001's current care plan found that the resident was required to have a specific type of texture modified fluids, this was also documented on the dining room diet roster.

During an interview with Inspector #593 on September 3, 2015, #S-100 reported that some of the thickened fluids were pre-prepared however some they prepare themselves in the kitchen. They further reported that they use the instructions on the label which advised to use one tablespoon per cup, however they use three teaspoons which works out about the same. They referred to the instructions on the pack which read 1.5 tablespoons. They find that three teaspoons makes it the right consistency. They added that they make all the fluids to one level of fluid consistency.

Observations by Inspector #593, found that the instructions on the thickener label were guidelines for usage per 118ml of fluid. The chart for fluid measurement used for recording fluid intake indicated the following:

Small coffee cup- 220ml
Large coffee cup- 240ml
Small glass- 150 ml
Large glass- 175ml
Nosey cups- 125ml

During an interview with Inspector #593 on September 3, 2015, the Team Lead of food services reported that some of the thickened fluids are purchased by the home and they also use a powdered thickener which has instructions on the label which staff were supposed to follow.

During an interview with Inspector #593 on September 2, 2015, the RD reported that they completed an in-service for staff within the past six months on thickening fluids. They also prepared a set of instructions for thickening fluids which they printed for dietary staff. They further added that the instructions were also on the label of the thickener and these instructions were what staff should be referring to.

During an interview with Inspector #593 on September 3, 2015, the Administrator reported that the staff were supposed to be following the manufacturer's instructions on the label of the thickener, they also added that the RD gave an in service on preparing thickened fluids correctly including a set of printed instructions that staff could refer to when thickening fluids.

During an interview with Inspector #593 on September 4, 2015, the Administrator reported that they checked with the dietary staff and the instructions for preparing thickened fluids that were provided by the RD, were removed from the thickener container a while ago and since have been thrown away.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 11. (2) Every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. [s. 11. (2)]

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. 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,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home includes alternative choices of entrees, vegetables and desserts at lunch and dinner.

On September 1, 2015, during the lunch meal service, the inspector observed a pureed meal of a turkey sandwich, mixed vegetables and bean salad being provided to residents requiring a pureed diet. There was no second choice of entrée or vegetables observed to be offered to residents requiring a pureed diet.

On September 1, 2015, during the lunch meal service, the inspector observed #S-100 offer and provide desserts to residents in the dining room. The selection for residents requiring a pureed diet included apple sauce. There was no second choice of dessert observed to be offered or provided to residents requiring a pureed diet.

During an interview with Inspector #593 on September 1, 2015, #S-100 reported that the pureed turkey sandwich, pureed mixed vegetables and pureed bean salad was the only option for residents requiring a pureed diet.

During an interview with Inspector #593 on September 3, 2015, #S-100 reported that there was a second choice tray puree available for residents requiring a pureed diet during the lunch service on September 1, 2015. The staff member also reported that because there was enough pureed turkey sandwich, they knew they were not going to run out and therefore they served everyone the turkey sandwich first and did not need to offer the tray puree.

During an interview with Inspector #593 on September 3, 2015, the Team Lead of food services reported that there should always be second choice for residents requiring a pureed diet. They added that at lunch, a puree tray will be offered as a second choice and at dinner, a puree tray will be offered as a third choice. [s. 71. (1) (c)]

2. The licensee has failed to ensure that the home offered a between meal beverage to residents in the afternoon.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart pass resident #001's room on two occasions. The resident was observed to be in their room at this time, however the resident was not offered or provided a beverage from the cart.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart enter the common living area of the home. Resident #004 was seated in this area however they were not offered or provided a beverage at this time. The PSW was then observed to take the nourishment cart back to the kitchen.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; pursuant to O.Reg 79/10, r. 71. (3) (b) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. [s. 71. (3) (b)]

3. The licensee has failed to ensure that the home offered residents a snack in the afternoon.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart pass resident #001's room on two occasions. The resident was observed to be in their room at this time, however the resident was not offered or

provided a snack from the cart.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart enter the common living area of the home. Resident #004 was seated in this area however they were not offered or provided a snack at this time. The PSW was then observed to take the nourishment cart back to the kitchen.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; pursuant to O.Reg 79/10, r. 71. (3) (c) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. [s. 71. (3) (c)]

Additional Required Actions:

CO # - 004 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. 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:
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:
6. Food and fluids being served at a temperature that is both safe and palatable to the 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. 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. The licensee has failed to ensure that the home has a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

A review of resident #009's current care plan found that the resident required a specific fluid consistency related to associated risks however there was also a documented note stating "email request from DOC to change to a different fluid consistency". A review of the nourishment cart diet roster found that the resident was required to receive a specific

fluid consistency. A review of the dining room/kitchen diet roster found that the resident was required to receive a different fluid consistency.

A review of resident #008's current care plan found the resident required a specific fluid consistency related to associated risks. A review of the dining room/kitchen diet roster found no documentation related to the resident requiring a specific fluid consistency. A review of the nourishment cart diet roster found no mention of the resident requiring a specific fluid consistency.

A review of resident #007's current care plan found the resident required a specific diet texture. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific diet texture.

A review of resident #005's current care plan found the resident required a specific fluid consistency related to associated risks. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific fluid consistency.

A review of resident #004's current care plan found the resident required a specific fluid consistency of related to associated risks. A review of the nourishment cart diet roster found that the resident required texture modified fluids but it was not specified at which level. A review of resident #004's health care record found an order from the home's RD of a specific oral nutrition supplement at a specific fluid consistency.

During an interview with Inspector #593 on September 1, 2015, #S-106 reported that resident #004 required texture modified fluids and currently they were feeding resident #004 a specific texture modified fluid.

A review of resident #002's current care plan found the resident required a specific fluid consistency related to associated risks. This was also confirmed in a nutrition assessment completed for resident #002 which documented that the resident was to receive a specific fluid consistency. A review of the dining room/kitchen diet roster found that it was documented that the resident required a different fluid consistency. A review of the nourishment cart diet roster found that it was documented that the resident required a different fluid consistency.

During an interview with Inspector #593 September 2, 2015, the home's Registered Dietitian (RD) reported that resident #002 was to receive a specific type of texture modified fluids, they added that this resident was recently assessed by the Speech

Language Pathologist (SLP) and the same order for texture modified fluids as in the care plan was continued.

A review of the home's policy # DTY 215: Diet Orders, indicated that the RD or the Physician will prescribe all changes to the diet order and the RD will ensure that all diet changes have been recorded in the appropriate areas.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; and under inspection 2014_211106_0006, including a compliance order served April 25, 2014; pursuant to O.Reg 79/10, r. 73. (1) 5. 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. [s. 73. (1) 5.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes food and fluids being served at a temperature that is both safe and palatable.

On September 2, 2015, during the dinner meal service, the inspector observed a meal being served to resident #002. Assistance was not provided to this resident by staff until 1746h, 31 minutes after the meal was first served to the resident. A review of resident #002's current care plan found that they required assistance for feeding.

On September 2, 2015, during the PM nourishment pass, the inspector observed a meal being served to resident #004. Assistance was not provided to this resident by staff until 1740h, 25 minutes after the meal was first served to the resident. A review of resident #004's current care plan found that they required assistance for feeding.

During an interview with Inspector #593 September 3, 2015, the Administrator reported that they purposely changed the seating arrangement in the dining room to accommodate staff to feed two residents consecutively so that residents would not have to wait for feeding assistance. They added that the residents should not be served their meal until assistance is available as the meals would be cold.

On September 1, 2015, during the PM nourishment pass, the inspector observed the nourishment cart being delivered to the nurses' station from the kitchen at 1440h. Resident #002's specific oral nutrition supplement was observed on the cart at this time. This was not served to the resident until 50 minutes later, in which the specific oral

nutrition supplement was observed to be thin consistency.

During an interview with Inspector #593 September 2, 2015, the home's Registered Dietitian (RD) reported that the specific oral nutrition supplement was a special recipe for resident #002 and it should be taken out of the freezer only 15 minutes before serving to the resident. This was to ensure the correct consistency, also they would not want milk based products sitting out of the refrigerator for longer than this. [s. 73. (1) 6.]

3. The licensee has failed to ensure that the home has a dining and snack service that includes course by course service of meals for each resident.

On September 1, 2015 at 1235h, during the lunch meal service, the inspector observed #S-100 commence the serving of desserts to all residents seated in the dining room. It was observed that nine residents were still finishing their entrée at this time when the dessert was served to them.

On September 2, 2015 at 1740h, during the dinner meal service, the inspector observed #S-103 commence the serving of desserts to all residents seated in the dining room. It was observed that 25 residents had just been served their entrée or still finishing their entrée when their dessert was served to them.

On September 3, 2015 at 1222h, during the lunch meal service, the inspector observed staff commence the serving the entrée to all residents seated in the dining room. At least five residents were still finishing their soup when their entrée was served to them. At 1238h, #S-100 commenced serving desserts to all residents seated in the dining room. It was observed by the inspector, that 17 residents were still eating their entrée and three residents were still eating their soup when their dessert was served to them.

During an interview with Inspector #593 on September 3, 2015, the Administrator reported that at meal times the service should include course by course service and residents should not be provided the next course until they have finished the last, they added that it makes mealtimes more difficult as the dining tables become overcrowded. [s. 73. (1) 8.]

4. The licensee has failed to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On September 1, 2015, during the PM nourishment pass, the inspector observed #S-105 feed resident #002 an oral nutrition supplement. #S-105 was observed to be standing next to the seated resident while assisting them with their beverage.

On September 1, 2015, during the PM nourishment pass, the inspector observed #S-106 feed resident #004 a texture modified fluid. #S-106 was observed to be standing next to the seated resident while assisting them with their beverage.

On September 2, 2015, during the AM nourishment pass, the inspector observed #S-107 feed resident #004 a thickened fluid. Resident #004 was observed to be tilted back in their wheelchair while being assisted with the fluids and was observed to be coughing while receiving the fluids.

On September 1, 2015, during the AM nourishment pass, the inspector observed #S-107 feed resident #002 a texture modified fluid. #S-107 was observed to be standing next to the seated resident while assisting them with their beverage.

On September 1, 2015, during the AM nourishment pass, the inspector observed #S-107 feed resident #008 a texture modified fluid. #S-107 was observed to be standing next to the seated resident while assisting them with their beverage.

A review of resident #002's current care plan found that the resident had risks related to feeding and the interventions included, seat resident #002 at 90 degrees at meal times, staff to sit at resident #002's eye level, avoid standing to feed.

A review of resident #004's current care plan found that the resident had risks related to feeding. The interventions included to seat resident #004 at 90 degrees at meal times.

A review of resident #008's current care plan found that the resident had risks related to feeding and the interventions included, sit to feed, seat resident #008 at 90 degrees at mealtimes, staff sit at resident #008's eye level and avoid standing to feed.

During an interview with Inspector #593 on September 3, 2015, the Administrator reported that staff were not supposed to be standing while feeding residents, they added that no one wants somebody standing over them while being fed. [s. 73. (1) 10.]

5. The licensee has failed to ensure that resident #002 and #004 who require assistance with eating or drinking are served a meal until someone is available to provide the

assistance required by the resident.

On September 2, 2015, at 1715h during the dinner meal service, the inspector observed a meal served to resident #002. Assistance was not provided to this resident by staff until 1746h, 31 minutes after the meal was first served to the resident.

On September 2, 2015, at 1715h during the dinner meal service, the inspector observed a meal served to resident #004. Assistance was not provided to this resident by staff until 1740h, 25 minutes after the meal was first served to the resident.

A review of resident #002's current care plan found that this resident should not be left alone while eating or drinking due to associated risks and that resident #002 is fed by one staff for the majority of each meal.

A review of resident #004's current care plan found that this resident had risks related to feeding. Resident #004 was to be fed all meals and snacks and was to be monitored before returning to their room.

During an interview with Inspector #593 September 3, 2015, the Administrator reported that they purposely changed the seating arrangement in the dining room to accommodate staff to feed two residents consecutively so that residents would not have to wait for feeding assistance. They added that the residents should not be served their meal until assistance is available as the meals would be cold. [s. 73. (2) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a required policy, #035 Skin and Wound Care Program dated August 2012, is complied with.

Numerous times during the inspection, the inspector observed resident #001 in a specific position with their ambulation device with no support provided for the resident's feet.

A review of the home's Policy # NUR 035 Skin and Wound Care Program dated August 2012, found that for residents with specific altered skin integrity, the registered staff member is to initiate immediate nursing actions to address the identified risks including the OT/PT for further evaluation of the seating/positioning/equipment/therapeutic surface needs. For residents with pressure ulcers, obtain a seating assessment if the resident has an ulcer on a sitting surface and the PT/Rehabilitation Assistant are to assess and advise on positioning and seating options.

A review of resident #001's current care plan found that the resident had altered skin integrity and interventions to address this included to use a specific devices and to contact the Occupational Therapist (OT) or Physiotherapist (PT) as needed. There was no mention of the resident's positioning when using their ambulation device, or support for the resident's feet.

During an interview with Inspector #593 on September 4, 2015, #S-109 reported that resident #001 did not have support for their feet when they have had a previous supportive device, they do not use them anyway. During this interview, #S-110 repositioned resident #001 and left their feet without any support in front of Inspector #593 and #S-109. #S-109 turned to #S-110 and said "How would you feel if your feet were not supported"? #S-109 then further reported that the staff should not be leaving

this resident without foot support, they should prop them up using a stool or chair. They advised that otherwise it will be very uncomfortable for the resident and the resident was likely to get pins and needles in their legs.

During an interview with Inspector #593 on September 3, 2015, #S-111 reported that they were concerned that the resident does not have a supportive device for their feet and that their legs are not supported when in a specific position. They also believed that this is putting pressure on their altered skin integrity. They further added that they have mentioned this at staff meetings that the residents did not have any devices to support their feet.

During an interview with Inspector #593 on September 3, 2015, #S-112 reported that they usually put a chair in front of the resident for them to rest their legs on. They further advised that they did not know why the resident did not have supportive device for their feet, that perhaps they were taken away and this was used as a restraint measure. They further added that this may be in the resident's care plan but they were not sure.

During an interview with Inspector #593 on September 3, 2015, #S-108 reported that resident #001 is placed in a specific position to take pressure off their altered skin integrity. They added that when they do this, they place their legs on a chair to further relieve pressure from this area.

During an interview with Inspector #593 September 4, 2015, the Administrator reported that they were not aware that resident #001 did not have an assistive device for their feet and confirmed that this was not brought up at the last months falls/restraints committee meeting. The Administrator reported that this resident has not had a seating assessment completed by the PT or the OT. Regarding the intervention to place the residents legs on a chair, they were not aware of this and advised that it was not a bad idea but should be more permanent and added to the resident's care plan. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 5th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2015_380593_0023
Log No. / Registre no:	015648-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 8, 2015
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	NORTHWOOD LODGE 51 Highway 105, P.O. Box 420, RED LAKE, ON, P0V-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kandice Henry

To BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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 : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_246196_0007, CO #001;

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 is hereby ordered to complete a thorough review of each resident's plan of care, ensuring that the documented care is reviewed, updated and sets out clear direction to staff and others who provide direct care to the resident.

Furthermore, the licensee is to ensure that there is a process for PSW's to follow if the plan of care is not correct or could better reflect resident care needs, ensuring that the plan of care is current and communicated to all PSW's and that the documented care for each resident, meets their current assessed needs ensuring quality of care and quality of life.

This review and update of each resident's plan of care must be completed by November 6, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care for resident #001.

A review of resident #001's current care plan found interventions for a skin alteration including apply ointment/medications as ordered and cleanse with appropriate solutions and apply dressings as ordered.

A review of resident #001's health care record found a letter from the home's skin and wound care Registered Nurse in the Extended Class (RNEC) dated April, 2015, documenting the following: Swab altered skin for testing. Please irrigate altered skin with a specific solution daily cover with specific dressing. A handwritten note from the RNEC was added to this- "x 7d (for seven days) then reswab". When a specific treatment arrives start using with specific skin dressing.

A review of resident #001's September 2015 Treatment Administration Record (TAR) found treatment needed including: Skin assessment to altered skin area every two weeks on bath days and dressing to altered skin, see new orders, every three days and on bath day and PRN (as necessary).

During an interview with Inspector #593, the Administrator reported the home's skin and wound care RNEC left the clinic and therefore they do not have access to this service anymore. The Administrator reported that there should be an order for this resident related to their skin treatment, a copy of this order should be in the TAR binder. They reported that usually the skin and wound care RNEC would send through an order after the skin assessment was completed however this may have been missed due to them leaving the clinic. If the physician assessed a resident's wound, the registered nursing staff should be documenting this in the home's electronic documentation system (Goldcare) after the assessment had been completed. (593)

2. The licensee has failed to ensure that there was a written plan of care for residents #002, #005, #007, #008 and #009 that sets out clear directions to staff and others who provided direct care for the residents.

A review of resident #002's current care plan found that texture modified fluids were required related to associated risks. This was also confirmed in a nutrition assessment completed for resident #002 which documented that the resident was to receive texture modified fluids. A review of the kitchen diet roster found that it was documented that the resident required a different consistency of texture modified fluids. A review of the nourishment cart diet roster found that it was documented that the resident required a different consistency of texture modified fluids.

During an interview with Inspector #593 September 2, 2015, the home's Registered Dietitian (RD) reported that resident #002 was to receive a specific

type of texture modified fluids, they added that this resident was recently assessed by the Speech Language Pathologist (SLP) and the order for texture modified fluids was continued.

A review of resident #004's current care plan found that a specific consistency of texture modified fluids was required related to associated risks. A review of the nourishment cart diet roster found that the resident required texture modified fluids but it was not specified at which consistency. A review of resident #004's health care record found an order from the home's RD of an oral nutrition supplement at a specific fluid consistency.

During an interview with Inspector #593 September 1, 2015, #S-106 reported that resident #004 required a specific fluid conssitency and currently they were feeding resident #004 a different consistency of texture modified fluids.

A review of resident #005's current care plan found a specific fluid consistency required related to associated risks. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific fluid consistency.

A review of resident #007's current care plan found a specific diet texture requirement. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific diet texture.

A review of resident #008's current care plan found a specific fluid consistency required related to associated risks. A review of the kitchen diet roster found no mention of the resident requiring a specific fluid consistency. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific fluid consistency.

A review of resident #009's current care plan found a specific fluid consistency required related to associated risks however there was also a documented note stating "email request from DOC to change to different fluid consistency". A review of the nourishment cart diet roster found that the resident was required to receive a different fluid consistency. A review of the kitchen diet roster found that the resident was required to receive a specific fluid consistency as in the care plan. [s. 6. (1) (c)]

Non-compliance has been previously identified under inspection

2015_246196_0007, including a compliance order served May 25, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (1) (c) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

The decision to re-issue this compliance order was based on the scope which affected six residents, the severity which indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC continues with this area of the legislation. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_246196_0007, CO #007;

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 is required to prepare, submit and implement a plan for achieving compliance under s. 6. (7) of the LTCHA:

The plan must include, but is not limited to:

* A process to ensure that all residents requiring oral nutrition supplements, are provided the supplement that is ordered and that there is a documented record of the resident receiving the supplement.
* A process to ensure that staff are aware of their responsibilities in administering oral nutrition supplements, whether it is part of the Medpass, during meals or as part of the between meal nourishment passes.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. This plan must be received by October 22, 2015 and fully implemented by November 6, 2015.

This review and update of each resident's plan of care must be completed by October 30, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure the care set out in the plan of care was provided to resident #004 as specified in the plan, specifically related to the provision of oral nutrition supplements.

A review of resident #004's current care plan found that the resident was to receive a specific oral nutrition supplement at the PM snack. A review of the nourishment cart diet roster also documented this nutrition intervention.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart enter the common living area of the home. Multiple oral nutrition supplements were observed to be available on the cart. Resident #004 was seated in this area however they were not offered or provided an oral nutrition supplement at the time. The PSW was then observed to take the nourishment cart back to the kitchen.

During an interview with Inspector #593 September 2, 2015, the home's Registered Dietitian reported that resident #004 is required to receive a specific oral nutrition supplement at PM and HS snack. (593)

2. The licensee has failed to ensure the care set out in the plan of care was provided to resident #001 as specified in the plan, specifically related to the provision of oral nutrition supplements.

A review of resident #001's current care plan found that the resident was to receive a specific oral nutrition supplement at the PM snack. A review of the nourishment cart diet roster also documented this nutrition intervention.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart pass resident #001's room on two occasions. Multiple oral nutrition supplements were observed to be available on the cart. The resident was observed to be in their room at the time; however the resident was not offered or provided an oral nutrition supplement from the cart. (593)

3. The licensee has failed to ensure the care set out in the plan of care is provided to four residents as specified in the plan, specifically related to the provision of a texture modified diet.

Inspector #593 observed posted on the wall in the kitchen, a large photograph of a plate of ground meat. Written on the photograph was "please let the Administrator know if the minced does not look like this".

During an interview with Inspector #593 on September 3, 2015, the Team Lead of food services reported that toast is provided for residents requiring a minced

diet and the crusts should be cut off and the toast should be cut into pieces for the residents.

During an interview with Inspector #593 on September 2, 2015, the home's Registered Dietitian (RD) reported that the hospital needed to mince the food properly and that the expectation is that the minced food resembles ground beef. The RD added that all residents should be receiving the same texture if they are on a minced diet.

A review of the dining room diet roster found four residents were to receive a minced textured diet with "minced all" being documented. This was confirmed in the resident's plan of care.

On September 1, 2015, during the lunch meal service, Inspector #593 observed the following:

• One of the residents requiring a minced diet was provided a sandwich with sliced meat and salad, the crusts were left on and the sandwich was not cut up. The filling of the sandwich was not minced. The salad provided was not minced.

• One of the residents requiring a minced diet was provided a cut up toasted sandwich, the crusts were left on the bread. Later during the meal service, the resident was provided a second meal which was a sandwich and bean salad. This was not minced.

• One of the residents requiring a minced diet was provided a salmon sandwich, the crusts were left on and the sandwich was not cut up. There was a finely chopped salad served next to the sandwiches however this was not minced texture.

On September 2, 2015, during the breakfast meal service, Inspector #593 observed the following:

• One of the residents requiring a minced diet was provided toast with jam, the toast was not cut up nor were the crusts removed.

• One of the residents requiring a minced diet was provided two slices of toast sandwiched together, the crusts were cut off however the toast was not cut up.

• One of the residents requiring a minced diet was provided toast with jam, the crusts were cut off however the toast was not cut up.

• One of the residents requiring a minced diet was provided toast with jam, the crusts were cut off and the toast was cut up.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (7) Every licensee of a long-term care home shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The decision to re-issue this compliance order was based on the scope which affected six residents, the severity which indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including two compliance orders, NC continues with this area of the legislation. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_246196_0007, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s. 11. (2) of the LTCHA:

The plan must include, but is not limited to:

* A process to ensure that all staff are aware of their responsibilities in preparing or serving texture modified foods and fluids.
* Retraining for nursing and dietary staff on texture modified foods and fluids. The retraining must include the specifics of each diet texture and each fluid consistency and the correct way in which each is achieved.
* The details on who will provided this retraining to ensure that they possess the necessary expertise.
* The home's RD (or other appropriately qualified person) is required to prepare a reference document for preparation of thickened fluids which takes into consideration the volume of the fluid, the type of fluid, the measuring instrument to be utilized and the type of thickener to be used.
* The Nutrition Manager is to oversee the provision of meals and between meal nourishments, communicate regularly with the dietary staff and address issues with the process as and if they arise.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. This plan must be received by October 22, 2015 and fully implemented by November 6, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are provided with food and fluids that are safe.

Inspector #593 observed, a large photograph of a plate of ground meat posted on the wall in the kitchen. Written on the photograph was “please let the Administrator know if the minced does not look like this”.

During an interview with the inspector on September 3, 2015, the Team Lead of food services reported that toast is to be provided for residents requiring a minced diet and the crusts are to be cut off. In addition the toast should be cut into pieces for the residents.

During an interview with the inspector on September 2, 2015, the home’s Registered Dietitian (RD) reported that the hospital are required to mince the food properly and that the expectation is that the minced food resembles ground beef. The RD added that all residents should be receiving the same texture if they are on a minced diet.

A review of the dining room diet roster found that four residents were to receive a minced textured diet with "minced all" being documented. This was also documented in the resident's plan of care.

On September 1, 2015, during the lunch meal service, Inspector #593 observed the following:

• One of the residents requiring a minced diet was provided a sandwich with sliced meat and salad, the crusts were left on the bread and the sandwich was not cut up. The filling of the sandwich was not minced. The salad provided was not minced.

• One of the residents requiring a minced diet was provided a cut up toasted sandwich, the crusts were left on the bread. Later during the meal service, the resident was provided a second meal which was a sandwich and bean salad. This was not minced.

• One of the residents requiring a minced diet was provided a salmon sandwich, the crusts were left on the bread and the sandwich was not cut up. There was a

finely chopped salad served next to the sandwiches however this was not minced texture.

On September 2, 2015, during the breakfast meal service, Inspector #593 observed the following:

• One of the residents requiring a minced diet was provided toast with jam, the toast was not cut up nor were the crusts removed from the bread.

• One of the residents requiring a minced diet was provided two slices of toast sandwiched together, the crusts were cut off the bread however the toast was not cut up.

• One of the residents requiring a minced diet was provided toast with jam, the crusts on the bread were cut off however the toast was not cutup.

• One of the residents requiring a minced diet was provided toast with jam, the crusts on the bread were cut off and the toast was cut up.

On September 1, 2015, during the PM nourishment pass, the inspector observed the nourishment cart delivered to the nurses' station from the kitchen at 1440h. Resident #002's oral nutrition supplement was observed to be on the cart at this time. This was not served to the resident until 50 minutes later, in which the oral nutrition supplement was observed to be thin consistency.

A review of resident #002's current care plan found that the resident was required to have a specific fluid consistency related to associated risks.

During an interview with Inspector #593 September 2, 2015, the home's Registered Dietitian (RD) reported that the oral nutrition supplement is a special recipe for resident #002 and it should be taken out of the freezer only 15 minutes before serving to the resident. This was to ensure that the resident received the supplement at the correct consistency.

On September 1, 2015, during the PM nourishment pass, the inspector observed resident #004 being provided a texture modified beverage. #S-106 was observed to be assisting them with their beverage. It was observed that the only thickened fluid available on the nourishment cart was commercially prepared texture modified apple juice at a specific consistency.

During an interview with Inspector on #593 September 1, 2015, #S-106 reported that they were feeding resident #004 a texture modified beverage at a specific consistency as that is what was available to them on the nourishment cart.

On September 2, 2015, during the AM nourishment pass, the inspector observed resident #004 being provided a texture modified beverage. #S-107 was observed to be assisting them with their beverage and the resident coughed several times while being fed. It was observed that the only thickened fluid available on the nourishment cart was commercially prepared texture modified apple juice at a specific consistency which was different to what was specified in the resident's care plan.

A review of resident #004's current care plan found that the resident required texture modified fluids related to associated risks. A review of the nourishment cart diet roster found that the resident required the same texture modified fluids.

During an interview with Inspector #593 September 2, 2015, #S-107 reported that for all nourishment passes, they use the pre-thickened juices for all residents requiring thickened fluids. #S-107 indicated that the texture modified apple juice in a specific consistency was what they use for all residents requiring texture modified fluids during the nourishment pass. They added that they will specially prepare texture modified fluids for meals but not for the nourishment passes.

On September 1, 2015, Inspector #593 observed during the lunch meal service, a variety of texture modified fluids that were prepared by the dietary staff. There were three fluids prepared and served to residents #001, #002 and #004 and each of these fluids was observed to be a different consistencies.

On September 2, 2015, Inspector #593 observed #S-103 preparing texture modified fluids for the dinner meal service. During an interview with Inspector #593 on September 2, 2015, #S-103 reported that resident #004 was to receive a specific type of texture modified fluids however the remainder that required texture modified fluids were to receive a different consistency. They added that there were a few residents that required a third consistency of texture modified fluids however the staff would modify the beverage at the point of service if the resident required the fluids to be a different consistency.

On September 2, 2015, during the dinner meal service, the inspector observed resident #004 being served a texture modified meal of beef and vegetables. The texture modified beef and vegetables was observed to be thin consistency.

A review of resident #004's current care plan found that the resident required a specific consistency of texture modified foods. This was also documented on the dining room/kitchen diet roster and confirmed during an interview with the home's RD on September 2, 2015.

On September 3, 2015, Inspector #593 observed during the breakfast meal service, a selection of beverages that had been thickened by staff for resident's #001, #002 and #004. One of the beverages provided to resident #001 was observed to be regular consistency. Two of the beverages that were provided to resident #002 included a milk based drink that was regular consistency and an orange juice that was a texture modified consistency. Two of the beverages that were provided to resident #004 included a prune juice that was texture modified and a coffee that was a different consistency than the prune juice.

A review of resident #001's current care plan found that the resident was required to have a specific type of texture modified fluids, this was also documented on the dining room diet roster.

During an interview with Inspector #593 on September 3, 2015, #S-100 reported that some of the thickened fluids were pre-prepared however some they prepare themselves in the kitchen. They further reported that they use the instructions on the label which advised to use one tablespoon per cup, however they use three teaspoons which works out about the same. They referred to the instructions on the pack which read 1.5 tablespoons. They find that three teaspoons makes it the right consistency. They added that they make all the fluids to one level of fluid consistency.

Observations by Inspector #593, found that the instructions on the thickener label were guidelines for usage per 118ml of fluid. The chart for fluid measurement used for recording fluid intake indicated the following:

Small coffee cup- 220ml
Large coffee cup- 240ml
Small glass- 150 ml
Large glass- 175ml

Nosey cups- 125ml

During an interview with Inspector #593 on September 3, 2015, the Team Lead of food services reported that some of the thickened fluids are purchased by the home and they also use a powdered thickener which has instructions on the label which staff were supposed to follow.

During an interview with Inspector #593 on September 2, 2015, the RD reported that they completed an in-service for staff within the past six months on thickening fluids. They also prepared a set of instructions for thickening fluids which they printed for dietary staff. They further added that the instructions were also on the label of the thickener and these instructions were what staff should be referring to.

During an interview with Inspector #593 on September 3, 2015, the Administrator reported that the staff were supposed to be following the manufacturer's instructions on the label of the thickener, they also added that the RD gave an in service on preparing thickened fluids correctly including a set of printed instructions that staff could refer to when thickening fluids.

During an interview with Inspector #593 on September 4, 2015, the Administrator reported that they checked with the dietary staff and the instructions for preparing thickened fluids that were provided by the RD, were removed from the thickener container a while ago and since have been thrown away.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 11. (2) Every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

The decision to re-issue this compliance order was based on the scope which affected seven residents, the severity which indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC continues with this area of the legislation. (593)

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 : Nov 06, 2015

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_246196_0007, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under r. 71. (3) of the Regulations:

The plan must include, but is not limited to:

* Retraining for nursing and dietary staff regarding the home's nutrition and hydration program specifically related to the nourishment pass.
* The details on who will provided this retraining to ensure that they possess the necessary expertise.
* A process to ensure that staff are aware of their responsibilities in regards to the between meal nourishment pass.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. This plan must be received by October 22, 2015 and fully implemented by November 6, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the home offered a between meal beverage to residents in the afternoon.

On September 3, 2015, during the PM nourishment pass, the inspector

observed the nourishment cart pass resident #001's room on two occasions. The resident was observed to be in their room at this time, however the resident was not offered or provided a beverage from the cart.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart enter the common living area of the home. Resident #004 was seated in this area however they were not offered or provided a beverage at this time. The PSW was then observed to take the nourishment cart back to the kitchen. (593)

2. The licensee has failed to ensure that the home offered residents a snack in the afternoon.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart pass resident #001's room on two occasions. The resident was observed to be in their room at this time, however the resident was not offered or provided a snack from the cart.

On September 3, 2015, during the PM nourishment pass, the inspector observed the nourishment cart enter the common living area of the home. Resident #004 was seated in this area however they were not offered or provided a snack at this time. The PSW was then observed to take the nourishment cart back to the kitchen.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; pursuant to O.Reg 79/10, r. 71. (3) (c) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; pursuant to O.Reg 79/10, r. 71. (3) (b) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

The decision to re-issue this compliance order was based on the scope which affected two residents, the severity which indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC continues with this area of the legislation.

(593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2015

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2015_246196_0007, CO #008;

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 is hereby ordered to complete a thorough review of the nourishment cart diet roster and kitchen/dining room diet roster, ensuring that each resident's documented dietary requirements align with the residents current plan of care. In addition, the licensee is to implement a process to ensure that the diet rosters remain current with all resident dietary requirements if, and when they change.

Furthermore, the licensee is to ensure that there is a process for PSW's and dietary aides to follow if the diet rosters are not correct or could better reflect resident care needs, ensuring that the diet rosters are current and communicated to all PSW's and dietary aides ensuring that each resident is provided food and fluids that meet their dietary requirements ensuring quality of care and quality of life.

This review and update of the diet rosters must be completed by November 6, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the home has a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

A review of resident #009's current care plan found that the resident required a specific fluid consistency related to associated risks however there was also a documented note stating "email request from DOC to change to a different fluid consistency". A review of the nourishment cart diet roster found that the resident was required to receive a specific fluid consistency. A review of the dining room/kitchen diet roster found that the resident was required to receive a different fluid consistency.

A review of resident #008's current care plan found the resident required a specific fluid consistency related to associated risks. A review of the dining room/kitchen diet roster found no documentation related to the resident requiring a specific fluid consistency. A review of the nourishment cart diet roster found no mention of the resident requiring a specific fluid consistency.

A review of resident #007's current care plan found the resident required a specific diet texture. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific diet texture.

A review of resident #005's current care plan found the resident required a specific fluid consistency related to associated risks. A review of the nourishment cart diet roster found no documentation related to the resident requiring a specific fluid consistency.

A review of resident #004's current care plan found the resident required a specific fluid consistency of related to associated risks. A review of the nourishment cart diet roster found that the resident required texture modified fluids but it was not specified at which level. A review of resident #004's health care record found an order from the home's RD of a specific oral nutrition supplement at a specific fluid consistency.

During an interview with Inspector #593 on September 1, 2015, #S-106 reported that resident #004 required texture modified fluids and currently they were feeding resident #004 a specific texture modified fluid.

A review of resident #002's current care plan found the resident required a specific fluid consistency related to associated risks. This was also confirmed in a nutrition assessment completed for resident #002 which documented that the resident was to receive a specific fluid consistency. A review of the dining room/kitchen diet roster found that it was documented that the resident required a different fluid consistency. A review of the nourishment cart diet roster found that it was documented that the resident required a different fluid consistency.

During an interview with Inspector #593 September 2, 2015, the home's Registered Dietitian (RD) reported that resident #002 was to receive a specific type of texture modified fluids, they added that this resident was recently assessed by the Speech Language Pathologist (SLP) and the same order for texture modified fluids as in the care plan was continued.

A review of the home's policy # DTY 215: Diet Orders, indicated that the RD or the Physician will prescribe all changes to the diet order and the RD will ensure that all diet changes have been recorded in the appropriate areas.

Non-compliance has been previously identified under inspection 2015_246196_0007, including a compliance order served May 25, 2015; and under inspection 2014_211106_0006, including a compliance order served April 25, 2014; pursuant to O.Reg 79/10, r. 73. (1) 5. 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.

The decision to re-issue this compliance order was based on the scope which affected six residents, the severity which indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including two compliance orders, NC continues with this area of the legislation. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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