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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 12, 2018	2018_548592_0005	025592-17, 025593-17	Follow up

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère Street OTTAWA ON K1N 5C8

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

Residence Saint-Louis
879 Chemin Parc Hiawatha OTTAWA ON K1C 2Z6

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

MELANIE SARRAZIN (592)

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): March 16, 19, 20, 21, 22, 23 and April 03 and 04, 2018

The Inspection was related to the follow-up of two orders.
One order Log # 025592-17 related to the use of side rails and the second order Log # 025593-17 related to nutrition.
This inspection was also done concurrently with Inspection # 2018_548592_0006.
A finding under s.6(7) was identified during this inspection and will be issued under Inspection report # 2018_548592_0006.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director of Long Term Care (EDLTC), the Registered Dietician (RD), two Food Services Manager (FSM), the Maintenance Supervisor, several Dietary Aids, several Registered Nurses (R.N.), several Registered Practical Nurses (R.P.N.), Personal Support Workers (PSWs) and several residents.

During the course of the inspection, the inspector conducted a tour of the resident care areas, reviewed resident's health care records, relevant licensee policies and procedures relative to the use of side rails, observed staff work routines, posted menus, resident rooms, resident common areas, several meal services, the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Dining Observation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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
O.Reg 79/10 s. 15. (1)	CO #001	2017_548592_0021	592
O.Reg 79/10 s. 71. (4)	CO #002	2017_548592_0021	592

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).

Findings/Faits saillants :

The licensee has failed to ensure that the written plan of care set out clear directions to staff and
others who provide direct care to residents related to their nutritional likes and dislikes. (Log #025593-17)

On March 19, 2018, Inspector #592 observed the breakfast meal service on a specified unit dining room.

The menu choices according to the daily posted menu "day 08" which was posted in the dining room were:

Fruits of the day
Cold cereal
Hot cereal
Variety of toast
Omelet

Resident #004 was served a plate with bread, oatmeal and fruits. No eggs were offered. Inspector #592 reviewed the resident’s kardex at point of service and it indicated that resident #004 was not able to make choices for food preferences and that the staff members were choosing the best option based on the resident's likes/dislikes. The kardex at point of service also indicated that the resident needs assistance for eating, however the kardex did not indicate that resident #004 was not to receive eggs.

In an interview with PSW #116, the PSW indicated to the Inspector that resident's #004 meal was provided by the DA, therefore the PSW was unsure why resident #004 was not provided with eggs.

In an interview with RPN #105 who was present in the dining room, the RPN indicated that resident #004 does not like eggs and was spitting them, therefore the eggs were no longer being offered to the resident.

In an interview with DA #117 who provided the meal to PSW #116, the DA indicated that resident #004 does not like eggs and was spitting them out every time that eggs were being offered. When the Inspector inquired where to find the information for the resident likes and dislikes, the DA indicated that these were usually located in the resident’s

kardex and as well was mentioned to the DA several months ago by the family member of resident #004, however the DA was not able to locate the information.

In an interview with the Dietitian (RD), the RD indicated that the home has put a process in place for identifying the residents who were not capable of choosing their food preferences by obtaining information at the time of the residents' admission, from family and full time staff members in order to identify the likes and dislikes of the residents. The Dietitian further indicated that the residents identified with a "@" on their written plan of care and on the kardex, at the point of service, were not able to voice their meal preferences, therefore the staff were to refer to the residents likes, dislikes, diet specifications and allergies. The Dietitian further indicated that the PSWs knows the residents taste, however the PSWs still needed to observe the residents as the residents taste may change and they are to provide something else if the resident does not eat. The RD also told the Inspector that the staff should fill out a dietary consult, each time that the resident's likes and dislikes change in order for the RD to do the changes in the resident's written plan of care. When the Inspector inquired about resident #004 not being provided with eggs in the morning, the RD indicated not being made aware that resident #004 was not being provided/offered eggs and did not recall any particular specification by resident #004's family members related to eggs. The DR further indicated that if there is no specification of dislikes, the food items still needs to be offered to the resident and that a follow-up would be done with the staff members.

In a review of the resident's current written plan of care under nutrition and behaviours, there was no documentation about resident #004 being resistive and spitting eggs or other food items when being assisted with the meal service.

On March 20, 2018, the Inspector observed the breakfast meal service on the same unit. The RD who was present at the breakfast meal service asked the DA #117 if resident #004 was being provided with eggs at breakfast as per the meal menu when eggs were part of the meal service. The DA told the RD that eggs were only provided to resident #004 when regular staff were working as the resident had spit out offered eggs in the past and that it was unclear if the resident liked eating eggs.

On March 21, 2018, the RD indicated to the Inspector that upon staff interviews, resident #004 did not liked the eggs in the past, resulting of the resident spitting the eggs every time they were given. The RD indicated that the home had modified their eggs recipe several weeks ago which resulted of improving the eggs texture. The RD indicated that eggs were tried at breakfast time with the new texture and resident #004 ate them. The

RD further indicated that clarification was done in the resident's plan of care related to the eggs being provided to resident #004.

2. On March 20, 2018, Inspector #592 observed the breakfast meal service on a specified unit dining room.

The menu choices according to the daily posted menu "day 09" which was posted in the dining room were:

Fruit of the day
Cold cereals
Hot cereals
Variety of toast
Boiled eggs

Resident #010 was served by PSW #118, some toast, yogurt and fruits. No eggs and oatmeal were provided and the resident was not observed being offered these food choices.

Inspector #592 reviewed the resident's kardex at point of service and it indicated that resident #010 was on a specified diet, two food items were not to be provided and half portions. The kardex also indicated that the resident does not like a specific food item and is identified with an "@" as needed.

In an interview with PSW #118, the PSW indicated that resident #010 was not offered any food choices as the resident liked to have two specific food items at breakfast meal. PSW #118 further indicated that eggs and oatmeal had been tried in the past, however the resident was not eating them. Since these two food items were introduced to the resident, the resident eats all of offered breakfast. Inspector #592 observed that the resident ate the two items provided with a good appetite.

The RD who was nearby told the Inspector that no one had mentioned that resident #010 was not eating eggs and oatmeal at breakfast meal and that the resident should have been offered the food choices. The RD indicated that maybe the "@" as needed was not setting clear directions to staff members as it was put in place when the resident was occasionally not able to choose the food items. The RD indicated that the PSWs should offer the food item first and then go with the likes and dislikes of the resident if at a specific meal the resident is not able to choose. The RD further indicated that changes

will be done with the "@" as needed as it creates confusion among the staff members. The RD was also observed providing resident #010 some eggs which were not eaten by the resident.

It is to be noted that non-compliance was identified during this inspection which will be cross reference in Inspection # 2018_548592_0006.

Issued on this 12th day of April, 2018

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

Original report signed by the inspector.