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

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Inspection de soins de longue durée

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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
Dec 19, 2016	2016_511586_0012	031696-16	Resident Quality Inspection

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET WINDSOR ON N9G 1J6

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

SHELBURNE NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
200 ROBERT STREET SHELBURNE ON 000 000

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

JESSICA PALADINO (586), KATHLEEN MILLAR (527)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29 and 30, 2016.

The following Critical Incident System (CIS) Intakes were completed concurrently with the RQI:
028653-15 - Prevention of Abuse & Neglect
033326-16 - Falls Prevention
036315-15 - Falls Prevention
007746-16 - Falls Prevention
016967-16 - Falls Prevention
031834-16 - Falls Prevention
019166-16 - Personal Support Services
019997-16 - Prevention of Abuse & Neglect

The following Complaint Intakes were completed concurrently with the RQI:
019476-16 - Personal Support Services; Falls Prevention; Nutrition & Hydration; Prevention of Abuse & Neglect
019661-16 - Falls Prevention
022285-16 - Hospitalization & Change in Condition

The following On-Site Inquiry were completed concurrently with the RQI:
010628-16 - Prevention of Abuse & Neglect

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), the Director of Care (DOC), Food Services Supervisor (FSS), Activation Director, Restorative Care Coordinator (RCC), Resident Services Coordinator (RSC), Physiotherapist (PT), registered nurse (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident health records, internal investigative notes, policies and procedures; toured the home; and observed residents and care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **8 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure resident #028's substitute-decision maker (SDM) was given the opportunity to participate in the plan of care.

On November 25, 2016, a concern was brought forward by resident #028's SDM to the Long-Term Care (LTC) Inspector that on an identified date in 2016, they had discovered a concerning issue the resident was experiencing. When the SDM asked the staff how long this had been going on for, they were told it had been happening for three days. The family member was not made aware of this.

Documentation in the progress notes revealed that the resident was noted to be having this issue for two days prior.

Interviews with registered staff #100 confirmed that there was no documentation in the progress notes to demonstrate that the resident's SDM was contacted, though it was the expectation of the home that they should have been. Staff #100 and the DOC confirmed that the resident's SDM should have been notified of the change in the resident's health status prior to them discovering it on their own three days later. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in resident #023's plan of care was provided to the resident as per the plan.

Resident #023's documented plan of care directed staff to apply bed rails while the resident was in bed for safety.

On an identified date in 2016, PSW #124 was providing care to resident #023 in bed. According to the home's internal investigation notes and interview with the GM on November 22, 2016, the PSW left to go complete a task, and while doing so, did not put the bed rail back up into position. The PSW then heard a bang and went out to discover that the resident had fallen out of bed onto the floor, having sustained injury which required surgical intervention.

Interview with the GM on November 22, 2016, confirmed that the PSW should have put the bed rail back into position prior to leaving the resident's side, as per the resident's plan of care, and confirmed care was not provided to resident #023 as per their plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the care set out in each resident's plan of care is provided to the resident as per the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A) The licensee failed to ensure that the home's medication policy was complied with in keeping with s. 114 of the Regulation.

The home's policy, "Drug Inventory Control" (policy number 02-06-12, and last reviewed in June, 2014), directed staff to ensure that medications stored in refrigerators must be able to maintain a temperature of two to eight degrees Celsius, striving for an average temperature of five degrees Celsius, and that temperatures should be monitored daily. The "Public Health Ontario Vaccine Storage and Handling Guidelines, 2012", directed health care facilities to check and record the maximum, minimum and current temperatures twice daily in the temperature log book at the beginning and the end of

each day. The registered staff "Job Routines" were reviewed, which directed staff to check and record immunization refrigerator temperature in the DOC office. When the LTC Inspector reviewed the storage of medications in the vaccine fridge, it was identified that the monitoring, checking and recording of temperatures twice daily was not being completed consistently by the registered staff.

During the following months the vaccine fridge temperature was not checked and recorded to ensure the medications were maintaining their potency:
- July 2016, the vaccine fridge temperature was not checked and recorded eleven times.
- August 2016, the vaccine fridge temperature was not checked and recorded seven times.
- September 2016, the vaccine fridge temperature was not checked and recorded five times.
- October 2016, the vaccine fridge temperature was not checked and recorded four times.
- November from the 1 to 23, 2016 the vaccine fridge temperature was not checked and recorded twelve times.

RPN #100 and RN #126 were interviewed and identified that the registered staff were expected to follow the Public Health Guidelines, and their job routines for monitoring, checking and recording the vaccine fridge temperatures. The home did not comply with their policies, procedures, routines and guidelines for monitoring, checking and recording the vaccine fridge temperatures. (527).

B) The licensee failed to ensure that the home's preventative skin care policy was complied with in relation to s. 50 of the Regulation.

The home's policy, "Resident Therapeutic Care – Preventative Skin Care" (policy number RC – 4.220, effective November 2003), directed PSW staff to observe for and respond to resident verbalizations and behaviours indicative of skin discomfort.

On an identified date in 2016, resident #025's family member reported to the home that when PSW #105 was providing a particular type of care, the resident told the PSW they were hurting them; however, the PSW continued with the care.

Review of the home's internal investigation notes documented that during an interview with the GM the following day, the resident confirmed the occurrence, indicating that the PSW was hurting them and told them to stop. The resident's family member confirmed

that the resident was upset when they reported the incident. During an interview with the GM the day after the incident, PSW #105 confirmed that while the care was being performed that day, the resident vocalized their discomfort; however, they continued to perform the care to assist the resident appropriately. The PSW was counselled regarding the incident and confirmed that they should have handled the situation differently, respecting the resident's right to say no to care, especially when it was causing pain.

Interview with the GM on November 22, 2016, confirmed that PSW #105 continued to provide care to the resident even while they were verbalizing skin discomfort. [s. 8. (1)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's Drug Inventory Control and the Preventative Skin Care policies are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure resident #022 was protected from verbal abuse.

On an identified date in 2015, resident #022 reported to the RSC that the day prior, registered staff #123 said verbally abusive comments to them.

The home's internal investigation notes documented that the GM spoke with the resident four days later, who further confirmed the incident. The resident expressed their fear to the GM about having to see registered staff #123 again. The GM also indicated in the investigation notes that the resident was visibly distraught.

Interview with the GM on November 22, 2016, confirmed the incident, stating that registered staff member #123 made in appropriate comments to resident #022. Resident #022 was not protected from verbal abuse by registered staff #123. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every resident, including resident #022, are protected from abuse, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.
The home's policy, "Mandatory Reporting of Abuse/Neglect, Alleged Abuse/Neglect – Whistleblowing Protection" (policy number AB – 2.040, last revised 2010), directed any staff who were aware of or suspected abuse to immediately notify the GM and DOC of the incident, who would then submit the mandatory report to the Director.

A) On an identified date in 2015, resident #022 reported to the RSC that the day prior, registered staff #123 said verbally abusive comments to them. The incident was investigated by the home and verbal abuse was founded. The Director was not notified of the incident until three days after the occurrence. Interview with the GM on November 22, 2016, confirmed that the Director was not immediately notified of abuse that occurred in the home.

B) On an identified date in 2016, resident #026 was observed by PSW #125 to be inappropriately touching resident #018. The Director was not notified of the incident until 24 hours later, at the end of the following business day. Interview with the GM on November 22, 2016, confirmed that when an incident occurred in the home, front line staff typically notify the charge nurse, who would then notify the GM to create a Critical Incident System (CIS) report submitted to the Director. The GM confirmed that the incident happened on a weekend, and was not alerted until Monday; however, confirmed that since sexually inappropriate contact occurred, the GM should have been alerted immediately. The GM confirmed that the home's abuse policy was not complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Resident #012 had a fall on an identified date in 2016, causing injury. The physician ordered the resident to wear a particular intervention at all times in order to aid in the healing of their injury.

Registered staff #104, PSW #116 and #117 were interviewed on November 29, 2016, they confirmed that the resident had to wear the intervention all the time, and the PSWs documented each shift in the Point of Care (POC) electronic health record. The registered staff and the PSWs confirmed that the resident had worn this twenty-four hours per day until the physician had discontinued it. When the resident was interviewed on November 25, 2016, the resident confirmed they had to wear this; however could not remember any details. The clinical record was reviewed, which identified the POC documentation by the PSWs for each shift was inconsistently completed for that month in 2016. On two dates, there was no documentation by the PSWs on any shift. For a period of 25 days, there were ten shifts were at least two of the shifts there was no documentation related to the resident wearing their intervention at all times. Registered staff #104 confirmed that the PSWs were expected to document in the POC that the resident was wearing it at all times and this was not completed consistently.

B) Resident #012 had a fall on an identified date in 2016, which resulted in significant injury. The home implemented the "High Risk Falling Leaves Check List", which directed the PSWs to check the resident every half hour and to initial the check list. Registered staff #104, PSW #116 and #117 were interviewed on November 29, 2016, they confirmed that the resident had to be checked every half hour and the PSWs were expected to initial the check list located in the wall on the entrance of the resident's bed room. The registered staff and PSWs confirmed the resident was checked every half an

hour and probably even more often because they knew the resident's routine, so they were very diligent in their checks and monitoring of resident #012. PSW #117 stated that sometimes they get busy and do not have time or forget to document their initials on the check list, but the resident received the care that they needed. Reviewed the resident's clinical record and the PSWs had inconsistently documented on days, evenings and the night shift the half hourly safety checks for resident #012. Registered staff #104 and #126 confirmed the PSWs were expected to document their initials on the "High Risk Falling Leaves Check List" every half hour for each shift and this was not completed consistently.

The home failed to ensure that the interventions for resident #012 were documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a personal assistive services device (PASD) described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.
Resident #018 was observed using a particular PASD on November 16, 18 and 22, 2016. The resident was unable to physically or cognitively remove themselves from the PASD. The home's policy, "PASD" (policy number RC-3.220 and revised July 2010), was reviewed and directed staff to use a PASD when it would be effective to assist the resident with the routine activity of living. The home's PASD assessment was reviewed, which identified positioning, assisting with eating, and assisting with body positioning as reasons to implement a PASD, and also identified the particular device the resident was using as a type of PASD.
PSWs #105 and #106 were interviewed and identified that the resident was using the PASD for positioning, comfort, safety and eating. The PSWs were unsure if the device was a PASD, but confirmed that it assisted the resident with routine activities of daily living. RPN #100 and RN #104 confirmed that the device for resident #018 assisted the resident with activities of daily living, and were also unsure if the device was a PASD. The RCC was interviewed and indicated that they did not assess the resident for a PASD as they did not feel the device assisted resident #018 with activities of daily living and was as a PASD. The home failed to include resident #018's PASD in their plan of care. [s. 33. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a personal assistive services device (PASD) described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition, the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury had resulted in a significant change in the resident's health condition; and (b) where the licensee determined that the injury had resulted in a significant change in the resident's health condition or remained unsure whether the injury had resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

A) Resident #005 had a fall on an identified date in 2015. The resident had increased pain the following day, the physician adjusted the resident's pain medication and ordered an x-ray. When the x-ray was completed two days after the fall, and the home was notified the following day that the resident had a significant injury, resident #005 was subsequently transferred to the hospital for repair. The resident returned to the home five days later with a significant change in their condition. The critical incident was not reported to the Director until nine days after the incident.

B) Resident #029 had a fall on an identified date in 2015, which resulted in the resident

being transferred to the hospital. The resident was diagnosed with a significant injury. The resident returned to the home 10 days later, with a significant change in condition. The critical incident was not reported to the Director until 17 days after the incident.

C) Resident #012 had two falls in 2016. After both falls the resident was transferred to the hospital for assessment.

i. Resident #012 returned from the hospital after their first fall with a significant injury. Three days later, the resident went back to the hospital for further assessment and treatment. The resident was transferred to the hospital and returned with a significant change in condition two days later. The critical incident was not reported to the Director until 16 days after the incident.

ii. Resident #012 had the second fall which also resulted in significant injury. The resident returned from the hospital six days later with a significant change in condition. The critical incident was not reported to the Director until the following day, which was five days after the incident.

The DOC was interviewed and indicated that they were unsure whether the injury had resulted in a significant change in the health condition for resident # 025, #029 and #012 until they had returned from the hospital to the home, and that was the reason for the delay in reporting to the Director. The DOC and GM confirmed that the home did not notify the Director of the incidents no later than three business days after each critical incident occurred. [s. 107. (3.1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition, the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury had resulted in a significant change in the resident's health condition; and (b) where the licensee determined that the injury had resulted in a significant change in the resident's health condition or remained unsure whether the injury had resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4),, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart, iv. that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

On November 25, 2016, in the storage room that stored the government drug supply, the LTC Inspector observed nine boxes of Enemol Fleet Enemas, 130 millilitres per bottle, which expired in October 2016. The home's policy, "Disposal of Discontinued Medications" (index number 02-06-20, last reviewed in June 2014), directed staff to destroy and dispose of expired medications.

Registered staff #100 and #126 identified that the government stock of medications was checked on the night shift to ensure the home had enough medication supplies to meet the residents needs, and the night registered staff would also check the expiry dates on medications and remove from the supply so they don't get administered to residents. Registered staff #126 reviewed the night routine for the registered staff, which confirmed these expectations to remove expired medications from the government stock.

The home failed to ensure that the manufacturer's instructions for storage of the drugs in the government stock was complied with. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart, iv. that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting),, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration programs included, (ii) body mass index and height upon admission and annually thereafter.

The LTC Inspector identified during Stage I of the Resident Quality Inspection (RQI) that there were a number of residents in the home that had no annual heights completed in their clinical records. The home's policy, "Measuring Height” (policy number RC-3.680, effective December 2003), directed staff to take the residents height upon admission and annually within the first quarter of the calendar year. The policy also indicated that the annual height would help to determine the ratio between height and weight as related to the residents’ dietary requirements, and for the calculation of the resident’s individual creatinine clearance.

The "Weights and Vitals Summary" report was reviewed and it identified that seven residents in the home had no heights documented annually. Registered staff #100 and #101 identified that they were expected to complete annual heights on residents and document in Point Click Care (PCC). The DOC and the GM confirmed that staff were expected to complete annual heights on all residents during the first quarter of the calendar year, and document in PCC. The home did not ensure that all residents had their heights completed and documented annually in their clinical records. [s. 68. (2) (e) (ii)]

Issued on this 23rd day of December, 2016

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

Original report signed by the inspector.