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) :	MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2012_191107_0002
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Oct 25, 30, 31, Nov 1, 9, 15, 16, 2012
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BAYWOODS PLACE 330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~DIAN SHANNON~~ Kelly Kortkamen NW

To REVERA LONG TERM CARE INC., 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

Ministére de la Santé et des Soins de longue durée

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

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: 2011_066107_0010, CO #001

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall ensure that residents with significant weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 69.1] Section 69 Previously issued on September 28, 2011 as CO #001
The licensee did not ensure that resident #05 was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated after a significant weight loss of 7.8% over one month. Documentation did not reflect that an interdisciplinary assessment, including an assessment of factors contributing to the significant weight loss, was completed by the interdisciplinary team. Staff interview confirmed that action was not taken by the home to address the weight loss. Staff confirmed that a multidisciplinary assessment of the weight loss had not occurred and that a dietary referral to the Registered Dietitian had not been initiated. The home's Weight Management policy and procedure (LTC-H-340) stated that the Food Services Manager/Registered Dietitian (FSM/RD) would be notified of significant weight change via the Nursing/Dietary Liaison Form completed by the Registered staff by the 15th of each month if the FSM or RD has not already addressed the weight change. The Nursing/Dietary Liaison Form had not been completed, despite the significant weight loss being identified on the weight exception form. (107)
2. [O.Reg. 79/10, s. 69.1]
The licensee did not ensure that action was taken when resident #02 had a significant weight loss of 5% over one month. The registered dietitian reviewed the resident related to the significant weight loss and noted the resident had several meals less than 75% intake. Food and fluid intake records show the resident was consuming 79% of their meals at 1/2 or less over the month. The plan was to continue with the same interventions. No action was taken to address the noted poor intake. The resident was noted to have another significant weight loss the next month. (107)
3. [O.Reg. 79/10, s. 69.1]
The licensee did not ensure that resident #03 was assessed using an interdisciplinary approach, and that action was taken and outcomes were evaluated after a 16.3% significant weight loss over one month. Staff confirmed the significant weight loss was missed and also confirmed there was no referral to the registered dietitian for assessment of the weight loss. An assessment of the weight loss did not occur until almost two months later. (107)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2013

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2011_066107_0010, CO #002

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that:
a) The home's Registered Dietitian completes a nutritional assessment for residents when there is a significant change in residents' health status, and
b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).
The plan shall include:
a) training/education provided for Registered staff (Registered Nurse, Registered Practical Nurse, Registered Dietitian) in relation to the identification and assessment of residents who are not consuming adequate hydration, the referral process (Nursing/Dietary Liaison Tool), measures to address poor hydration and food intake, and the home's hydration management policy .
b) quality management activities the home has implemented, including the person responsible for the monitoring and the frequency of the monitoring.
The plan is to be submitted by December 3, 2012 to Long Term Care Homes Inspector Michelle Warrener, by e-mail at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 26(4)(b)] Previously issued September 28, 2011 as CO #002
The registered dietitian did not assess resident #03's hydration status and risks related to hydration.
a) At the nutritional review in an identified month in 2012, there was no mention of the resident's hydration status. Food and fluid intake records for that month reflected the resident had not met their hydration requirement (minimum of 1500ml/day) on 31/31 days, with 24/31 days at less than 1000ml of fluid intake. According to the home's hydration policy, a referral to the registered dietitian was to occur for 3 consecutive days of fluid intake 1000ml or less, however, there were no referrals related to poor hydration noted in the resident's clinical record during that time. The dietitian reviewed the resident related to poor skin integrity at the end of the month, however, there was no mention of the poor hydration and interventions to address the poor hydration were not implemented. Prior to the nutritional review, the resident also had fecal impaction, ongoing diarrhea, open areas on the skin (stage 2-3), fever, significant hypotension, 58% of meals the first 2 weeks of the month taken at 50% or less, however, there was no assessment of the resident's hydration status in relation to any of the identified risk factors and in relation to fluid goals identified on the resident's plan of care.
b) The resident continued with poor hydration for the next three months (80% of the time not meeting hydration requirement, 79% the next month, and 93% the subsequent month), without a referral to the registered dietitian for the poor hydration and without an assessment by the registered dietitian of the ongoing poor hydration. In two of the three months the resident was also noted to have urinary tract infections requiring antibiotics.
c) At the Resident Assessment Protocol (RAP) for Nutritional Status, significant weight loss was noted, however, there was no mention of an assessment of the resident's hydration in relation to their identified fluid goal and of the poor hydration. Five out of seven days during the observation period the resident was not meeting their hydration requirement.
d) The resident was reviewed by the registered dietitian again related to a skin tear, however, there was no assessment of the ongoing poor hydration. The resident had not met their hydration requirement on 22/25 days prior to the dietitian review. Eleven of the 22 days had fluid intake less than 1000ml/day. No interventions were implemented to address the poor hydration. (107)
2. [O.Reg. 26(4)(a),(b)]
The registered dietitian did not assess the nutritional and hydration status for resident #04 after a significant change in their food and fluid consumption.
a) The resident had a significant decrease in their food and fluid intake beginning three weeks prior to the quarterly review, however, this was not assessed by the Registered Dietitian in the Resident Assessment Protocol (RAP). The notes by the registered dietitian stated the resident had good intake at breakfast and 50-75% consumption at the lunch and supper meals. Food and fluid intake records reflect 89% of breakfasts were taken 1/2 or less (most was 1/4 or refused); 84% of the lunch meals and 70% of supper meals taken 1/4 or less over the three week time frame. The dietitian did not assess the significant decrease in food intake that occurred prior to the quarterly review and action was not taken to address the poor intake.
b) The resident also had a significant decrease in their fluid intake during the same time period. Prior to the decrease, the resident was consistently consuming more than 2000ml/day (goal for fluid intake was 1875ml/day), however, during the identified time frame the resident did not meet their hydration goal on any of the days monitored. The registered dietitian did not assess the resident's hydration status at the RAP; the RAP did not mention poor hydration and action was not taken to address the decreased fluid intake. (107)
3. [O.Reg. 79/10, s. 26(4)(b)]
The registered dietitian did not assess resident #01's hydration status, and risks related to hydration at the dietary review related to newly diagnosed diabetes. The resident's blood glucose was significantly elevated (registering HI on the blood glucose meter), however, the review did not include an assessment of the resident's fluid intake or anything related to the hydration status of the resident. An assessment of the resident's hydration requirements was not included in the resident's clinical health record (computer or paper copy on the floor), preventing early identification of risks related to hydration. Hydration was not assessed/mentioned at subsequent nutritional reviews two and three months after the first review. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2013

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant:

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 must prepare, submit and implement a plan that outlines how the home will ensure that the care set out in the plan of care for all residents related to fluid consistency, meal services, and required level of assistance with eating, will be provided to the residents as specified in their plans. The plan shall include monitoring, analysis and evaluation activities.
The plan is to be submitted by December 3, 2012 to Long Term Care Homes Inspector Michelle Warrener, electronically by e-mail to: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued January 28, 2011 as a VPC; February 28, 2011 as a VPC; and June 22, 2011 as a CO.
The licensee did not ensure that the care set out in the plan of care for the following residents was provided to the residents as specified in their plans:
a) The licensee did not ensure that the care set out in the plan of care for resident #09 was provided to the resident at the lunch meal October 25, 2012. The resident had a plan of care requiring thickened consistency fluids and they were at risk for aspiration pneumonia due to swallowing concerns. The resident was provided a consistency of fluids that was thinner than required and the resident was coughing significantly while consuming the fluids. Staff interview/record review confirmed that the resident required a thicker consistency of thickened fluids and staff confirmed that the fluids the resident was consuming were able to be poured from the glass (not thick enough), creating a risk for aspiration pneumonia.

b) Resident #08 had a plan of care requiring supervision and cueing at meals. The plan stated the resident would eat if sandwiches were placed in their hand. At the lunch meal October 31, 2012, the resident's sandwich was not placed in their hand until after they were sitting at the table not eating for more than 10 minutes. Only towards the end of the meal service did staff come and assist the resident with eating.

c) Resident #06:
i) The resident was not provided with the level of assistance required for eating as identified in their plan of care. The resident had a plan of care for constant supervision and encouragement with physical assistance if needed at all meals. The resident sat sleeping in-front of their meal for over 10 minutes with no assistance provided by staff. The resident's plate was removed without assistance being provided and the resident did not consume their meal.
ii) Resident #06 had a plan of care for the prevention of weight loss (resident was receiving nutritional supplementation several times daily and was several kilograms below their goal weight range), however, the resident was provided diet juice at the observed lunch meal October 30, 2012.

d) The licensee did not ensure that the care set out for resident #07 was provided to the resident as specified in their plan at the lunch meal October 30, 2012.
i) The resident had a plan of care that required double portions of meat at meals. At the observed lunch meal, the resident received a single portion of meat (sausage).
ii) The plan of care stated to cut the resident's food up into bite sized pieces, however, the resident received whole pancakes and sausage that was not cut up for the resident.
iii) The plan of care indicated the resident required encouragement at meals, however, the resident sat in-front of their hot meal for more than 15 minutes without encouragement or assistance by staff. The resident had their eyes closed at the table.

e) Resident #03:
i) The resident had a plan of care that required high protein milk, however, this was not provided to the resident at the lunch meal October 30, 2012. The diet list had not been updated to reflect the requirement for high protein milk. Staff serving the lunch meal were not aware that the resident requirement high protein milk at the meal.
ii) The resident had a plan of care that stated double portions of meat at meals, however, the resident was provided only a single portion of meal (sausage) at the observed lunch meal October 30, 2012. Staff interview confirmed the resident was not provided the double portion of meat by error. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2013

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 16th day of November, 2012

Signature of Inspector / Signature de l'inspecteur : M Warrener, HO

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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