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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2015;	2015_285126_0035 (A1)	O-002646-15	Resident Quality Inspection

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

ÉLISABETH-BRUYÈRE RESIDENCE
75 BRUYERE STREET OTTAWA ON K1N 5C8

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

JOANNE HENRIE (550) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date changed to January 25, 2016 as requested by the Executive Director. This will allow more time for the home to ensure the changes they have implemented are working and allow them to train all the staff as some are away for the holidays.

Issued on this 17 day of December 2015 (A1)

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

Original report signed by the inspector.

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

JOANNE HENRIE (550) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 28-29-30, October 1,2,5,6,7,8, and 9, 2015

The following inspections were conducted during the RQI:

Log# O-001921-15 Critical Incident

Log# O-000467-15 Critical Incident

Log# O-002256-15 Complaint

During the course of the inspection, the inspector(s) spoke with the Executive Director of Long Term/Administrator, the Advanced Practice Nurse for LTC and Clinical Manager (Director of Care (DOC)), Residents, Family members, Volunteers, Students, the President of the Residents' Council, the Director of Mission Ethics, Compliance, and Client Relations, Registered Nurses (RN's), Registered Practical Nurses (RPN's), Personal Care Attendants (PCA's), the Administrative Assistant, Housekeeping Attendants, Food Service Attendants (FSA's), a Diet Technician, the Registered Dietitian (RD), the Manager of Food Services, a Meal Helper, the Supervisor of Housekeeping and Environmental Services, the Recreation Technician, a Physician, a Physiotherapy Assistant, and a Medical Records Technician.

During the course of the inspection, the inspector(s) toured residential and non

residential areas, observed several meal and snack services, reviewed several of the home's policies and procedures, observed a medication pass including medication room, observed recreation activities, observed exercise therapy, reviewed minutes for Residents' Council and Family Council, reviewed the Quality Improvement Committee, reviewed Resident Health Care records, reviewed the Recreation Calendars, reviewed staffing schedules, reviewed food service documentation, reviewed cleaning schedules, and reviewed maintenance schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Snack Observation

Sufficient Staffing

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

10 WN(s)
5 VPC(s)
2 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 O.Reg 79/10, s. 73. Dining and snack service

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #008 and Resident #021 were served course by course. 0. Reg 79/10, s. 73 (1) (8)

At lunch, on October 6, 2015, in between the soup and main course, Resident #008 was observed eating pudding. At 12:27, he/she received the main course. At 12:49, it was noted that the resident was still eating pudding and the uneaten entree remained in front of him/her. Resident #008's care plan was reviewed, and there is no indication that meals are not to be served course by course.

At supper, on October 6, 2015, Resident #021 was served the main course at 17:05. At 17:11, the resident was observed to be eating pudding, and the uneaten entree was pushed to the side.

2. The licensee has failed to ensure that 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. 0.Reg 79/10,s.73(2)(b)

On October 6, 2015, lunch and supper meal service was observed on the fifth floor which has two dining areas: the Trillium Room (main dining room with seven tables) and the Seguin's Room.

The following observations were made in the Seguin's Room which has three tables for
nine residents.

Resident #045:

At 12:05, Resident #045 was served soup. At 12:07, the resident was sleeping. The resident did not attempt to feed himself/herself. Nine minutes after receiving the soup, at 12:14, a PCA sat and assisted the resident to eat. At 12:29, Resident #045 received the main course and was assisted to eat by PCA, S #114 who then left to assist a resident in the Trilluim Room. At 12:47, Resident #006, who sits at the same table, was heard saying to a student that Resident #045 needs Ensure and apple juice. Resident #045's beverages had not been completed, and the resident did not attempt to drink independently. The student sat and assisted the resident to complete the beverages.

At 17:02, Resident #045 was served the main course and did not attempt to feed

himself/herself. At 17:08, PCA, S #133, put Resident #045's fork in the meat. She did not encourage the resident to eat or provide assistance. Resident # 006, who sits at the same table, was heard saying, I thought she was going to help you. Resident #045 's table mates (Resident #006 and Resident #018) were heard telling the resident that once he/she took a bite on his/her own, then staff would come and help. The resident took one bite on his/her own with cueing and encouragement from his/her table mates. Resident #018 was heard saying to Resident #045, Use your spoon, that is excellent. At 17:22, twenty minutes after receiving the main course, PCA, S #132 sat and assisted Resident #045 to eat.

According to Resident #045's care plan, he/she is blind and requires staff to describe where the food is on the plate, place all items within reach and assist the resident to eat when needs help.

Resident #003:

At 12:05, Resident #003 was served soup. The resident was seated in the wheel chair which was positioned at an angle, facing away from the table. Resident# 003 did not attempt to feed himself/herself. Five minutes after receiving the soup, at 12:10, a PCA sat and assisted him/her to eat. At 12:27, Resident #003 was served the main course and did not attempt to feed himself/herself. At 12:33, PCA, 8#113 was assisting Resident #017 when the resident's family member arrived and took over assisting the resident.
PCA, S #113 then moved and assisted Resident #003 to eat the main course five minutes after Resident #003 had been served.

At 1705, Resident #003 was served the main course. At 17:08, PCA, S #133 sat to assist the resident. At 17:10, the staff member left to assist Resident #017 at another table. Resident #003 did not attempt to feed himself/herself. The staff member returned and resumed feeding Resident #003 six minutes later when Resident #017 had completed his/her meal.

Resident #008:

At 12:05, Resident #008 was served soup. The resident did not attempt to feed himself/herself and repeatedly said May I have a hot cup of coffee and a drop of milk. Five minutes after receiving the soup, at 12:10, a PCA sat and assisted him/her to eat. At 12:24, it was noted that Resident #008 was eating pudding and drinking coffee. At 1227, the resident was served the main course. At 12:49, it was noted that the

resident was eating pudding, and the uneaten entree remained in front of him/her. Assistance was not provided for Resident #008 to eat the main course.

On Resident #008's kardex, there is a hand written notation dated August 20, 2015, indicating that the resident is a feeder.

At the lunch meal on October 6, 2015, there were two PCAs assisting residents in the Seguin's Room and one PCA taking orders and serving the residents in the Seguin's and the Trillium Room, and PCA, S #114 indicated that this was the common practice. The DOC stated that her expectation was that were two PCAs in the Trillium Room and one PCA in the Seguin's Room during the lunch meal. Four PCA students were also present for part of the lunch meal. [s. 73.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's cycle menu includes menus for regular, therapeutic and texture modified diets for snacks. 0. Reg 79/10, s.71 (1)(b)

In interviews with residents, some residents expressed concern regarding not being consistently offered foods and/or fluids between meals and after dinner which

prompted an inspection into the snack menu.

In an interview with the Patient Menu Coordinator and the Nutritional Care Manager, it was reported that the home does not currently have a snack menu for regular, therapeutic and texture modified diets. It was reported that in order to receive a regular snack, it must be prescribed for a specific resident by the Registered Dietitian.

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

During interviews with residents, several reported not being offered fluids between meals.

PCA, S #121 stated that on most days a volunteer offers residents juice in the morning She stated that if no volunteer is present, staff are expected to offer the residents a beverage. She stated that time did not permit for this task to be completed, and a beverage was not offered to residents in the morning if a volunteer did not complete the task.

PCA, S #114 stated that by the time residents have completed their breakfast and are out of the dining room, it is 10:00 so residents were not offered a beverage between breakfast and lunch. She stated that residents' morning intake of beverages came from at breakfast and with medications.

On October 6, 2015, a portion of the afternoon nourishment pass was observed on the fifth floor. On the cart were three containers of regular consistency juice. There was no beverage to accommodate residents who require a thickened liquid consistency. There was no water to be offered to the residents who may have desired it.

The Diet Technician/Food Services Supervisor was interviewed and indicated that the current expectation was to offer all residents a beverage between meals once daily in the afternoon. She stated that residents were to be offered apple juice. She stated that beverages that were prescribed by the Registered Dietitian would be offered to those specific residents in the morning or in the evening after dinner.

3. The licensee has failed to ensure that residents were offered a a minimum of a snack in the afternoon and evening. 0. Reg 79/10, s. 71 (3)(c)

During interviews with residents, several reported not being offered a snack in the afternoon and evening.

The Diet Technician/Food Services Supervisor was interviewed and indicated that the current expectation was to offer all residents a snack once daily in the afternoon. She indicated that for the afternoon snack, residents on regular and soft textured diets were to be offered digestive cookies, and residents on minced and pureed diets were to offered vanilla or greek yogurt, unless a different afternoon snack had been prescribed by the Registered Dietitian. She stated that only snacks prescribed by the Registered
Dietitian would be offered to those specific residents in the evening.

PCA, S#122 was interviewed and stated that not all residents received an afternoon snack. He stated that there were labelled snacks for some residents. On October 6, 2015, S #122 was observed circulating the nourishment cart on the fifth floor, commencing at approximately 1445. On the cart for snack for all residents on the floor were 1-2 packets of soda crackers, 1-2 packets of melba toast and one container of peach yogurt. The PCA stated that normally there would be a tray in the servery fridge with labelled snacks, but that there was no tray or labelled snacks on that day, therefore only what was on the nourishment cart is what was offered to the residents.

On October 7, 2015, it was noted that in the fifth floor servery there were fifteen labelled snacks to be offered in the evening to residents. The other residents would not be offered an evening snack.

The Patient Menu Coordinator and Nutritional Care Manager were interviewed and stated that residents who indicated to the Registered Dietitian that they wanted a snack, received a labelled snack that was prepared at an off-site location.

4. The licensee has failed to ensure that planned menu items were offered and available at each meal. 0. Reg, s.71(4)

During the course of the inspection, several dining observations were completed on both
floors of the home.

On October 6, 2015, at lunch, tomato and rice soup and cream of potato soup were listed as menu Hems.-The entire lunch meai was observed on the fifth floor, and Resident #017, Resident #021 and Resident #011 who were seated at a table in the

Seguin Room were not offered soup. Soup was available and offered to the other six residents in the dining room.

On October 6, 2015 at supper, creamy coleslaw was listed as a menu item. The Dietary Aide, S# 125 showed Inspector #551 an inventory of all of the supper meal items, and creamy coleslaw was not among them. The entire supper meal was observed on the fifth floor, and creamy coleslaw as indicated on the menu was not offered and available.

On October 7, 2015 at breakfast, stewed prunes were listed as a menu item. Dietary Aide, S #115 stated that stewed prunes used to come pre-portioned, but that they have not been available for a while. In an interview with Inspector #545, Resident #016 expressed concern that the stewed prunes were not available. The entire breakfast meal was observed on the sixth floor, and stewed prunes as indicated on the menu were not offered and available.

On October 6, 2015, it was noted that Resident #003 did not have any beverages at his/her place setting. At 12:10, Resident#003 was provided assistance to eat the soup. At 12:33, Resident #003 was provided assistance to eat the main course, and at 12:44, was served ice cream. At no time during meal service did he/she receive a beverage to drink.Although no specific beverage is indicated on the lunch menu, the beverage cart was noted to contain a variety of beverages. No beverage was offered to Resident #003 at
the lunch meal. Resident #003's kardex was reviewed, and there is no indication that he/she is not to be offered beverages at meal time. [s. 71.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 is a written plan of care for each resident that sets out, the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident.

Resident #023 was admitted to the home on a specific day of May with several medical conditions, including heart disease and Alzheimer'. The Resident was admitted from hospital with an indwelling catheter in place for comfort measures. The 24-hr plan of care developed by the admission nurse indicated that the Resident was continent of urine, but did not indicate that the Resident had an indwelling catheter in place.

During observations on September 30, October 7 & 9, 2015, Inspectors #554 and #550 observed a strong odor of urine in Resident #023's bedroom. A catheter with a small amount of dark concentrated amber urine was observed in the urine collector bag, hanging from the Resident's bedrail.

The most recent assessment in September 2015 indicated that Resident #023 was totally dependent of all aspects of the activities of daily living. The assessment also indicated that the Resident was continent of urine with an indwelling catheter in place and that there had been no change in urinary continence in past 90 days.

The home keeps in a binder at the Nursing Station all of the Resident's Plan of Care

and Kardex. Inspector #545 reviewed the binder and was unable to find a Plan of Care and/or Kardex that set out catheter care and all other care for Resident #023. A review of the Resident's health record was also conducted, and an order for an indwelling catheter was not found.

PCA #S132 indicated to the Inspector that she did not think that the Resident's Plan of Care included any specific care in relation to the catheter care. She further indicated that the catheter bag was changed twice weekly on the same day of the Resident received a tub bath, and more often when the bag was crusty and/or if it smelled strong.

During interviews with Registered Practical Nurse(RPN) #S129 and Registered Nurse (RN) #S 1 06, they indicated that Resident #023's Plan of Care had not been developed since the admission in May 2015 and that there was no clear direction to staff in regards to catheter care. They also confirmed that an indwelling catheter had not been prescribed by the attending physician. RPN #S129 indicated that Resident #023 had silicone catheters in place and that these catheters were usually changed every three months, and that she relied on her memory and past progress notes to know when to change the catheter. She further added that if the catheter had been prescribed, an order in the Medication Administration Record would be indicated as a reminder.

During an interview with the Clinical Manager on October 9, 2015, she indicated that the home's expectation was to have a written Plan of Care developed and printed for all Residents including Resident #023, including the goals the care was intended to achieve and clear directions to staff and others who provide direct care to the Resident. She indicated that Resident #023's did not have a written Plan of Care. [s. 6. (1)]

2. 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 Resident #009.

On a specific day in August 2015, Resident #009 had a fall in the bathroom, trying to flush the toilet. Post fall assessment progress notes indicated that the resident was complaining of pain in the left knee, left hip and left shoulder. X-rays were done and were negative for a fracture. Resident was diagnosed with pain and was started on a pain medication.

On a specific day in September 2015, Resident #009 was assessed by the

Physiotherapy. The Physiotherapist assessment notes indicated that the Resident was refusing to use a wheel chair to go for meal and was choosing to have his/her meals in the bedroom. Resident was ambulating in the room with a walker and required assistance from one staff for shorter distance and was going to use the scooter for longer distance. None of these changes in resident's condition were documented in the plan of
care, no clear direction related to the Resident's change in mobility, eating and pain management.

On a specific day in September 2015, Resident #009 fell in the bathroom during the night and was transferred to the hospital. The fall resulted in a fracture and required surgery. Resident #009 was discharge back to the home on a. specific day in October 2015. Resident #009 had significant changes in his/her condition. Resident #009 was bedridden and was observed to have a pressure ulcer and required to be repositioned every 2-3 hours.

On October 10, 2015, discussion held with Registered Nurse (RN)#S 106 who indicated that the written plan of care was not updated since the return of Resident #009 on a specific day in October 2015 to reflect the actual care needs (incision care, mobility requirement needs, pressure ulcer treatment, positioning and pain management)

On October 10, 2015, discussion held with the Director of Care who indicated that the written plan of care was not updated since the return of Resident #009 on a specific day of October 2015 to reflect the actual care needs. The DOC indicated that the written plan of care would be updated today to give clear directions to staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that care set out in the plan of care provided to the resident as specified in the plan.

Resident #017 is diagnosed with a brain disorder, requiring extensive assistance with all activities of daily living such as personal hygiene including mouth care and brushing of teeth.

During an interview with the Resident on September 29, 2015, he/she indicated to the Inspector that staff did not provide assistance with brushing his/her teeth after each meal as was requested.

Upon review of the Annual Conference Notes dated a specific day in June 2015 it was indicated that Resident #017 and his/her family had voiced concerns regarding not receiving assistance with brushing of teeth after each meals. It was also indicated that the Resident could not brush his/her teeth on his/her own.

The most recent Plan of Care was reviewed by the Inspector. Under the section for Dental care, interventions included: lubrication of the Resident's mouth/lips, cleaning of mouth and tongue each morning, evening and after meals, and for staff to do oral hygiene.

During an interview with PCA S#113 on October 6, 2015, she indicated that she was a full-time employee and knew Resident #017 well. She indicated that she had access to the Plan·O'feare at the Nursing Station. When asked if she provided mouth care to Resident #017, she indicated that she brushed the Resident's teeth before breakfast while providing morning care, but not at other times such as after breakfast and/or lunch. She later indicated that she had not reviewed the Resident's Plan of Care and was
unaware of the interventions set for this Resident. [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 plan of care for Resident #023 set out the planned care, the goal and clear direction to staff, to ensure the plan of care set out clear directions to staff who provide direct care to Resident #009 and to ensure care is provided as set out in the plan of care of Resident #017, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall:
(b) clearly set out what constitutes abuse and neglect
(d) contain an explanation of the duty under section 24 of the Act to make mandatory reports

During an interview with Resident #019 on September 29, 2015, the Resident indicated that on a s~cific. day in August ~015 a male PCA.held on to his/her arms very tightlywhile he was drying him/her after giving a bath. The Resident indicated that he/she told the PCA to stop pinching him/her that hard as he/she would bruise. The Resident indicated to the Inspector that a family member encouraged him/her to report the incident to the registered staff which he/she did three days later and again on the following day.

Progress Notes were reviewed by the Inspector.

·A note documented on a specific day of August 2015 indicated that in the evening, Resident #019 reported to RN #S130 that a male PCA had held his/her arms very hard during bath care and had caused bruising. The note indicated that two bruises were observed: bruise on the left arm measured 2.5cm-3cm, and the one on the right arm measured 1 em. The note ends with "Will follow-up".

• A note documented on following day of August 2015 indicated that the Resident explained to the night RN how the bruises on his/her arms got there. The note further indicated that support was provided, nursing staff will continue to monitor.

During an interview with RN #S130, she indicated she remembered the incident when Resident #019 reported how the bruising on his/her arms came upon. RN #S130

indicated that a physical abuse is when someone causes harm to another person, for example hits them intentionally or by accident runs into them with a wheelchair. The RN indicated that it was busy the evening of that specific day in August 2015 and she did not notify the nursing supervisor (or the Clinical-on-Call if the nursing supervisor was not
available), further added that she selected to inform the night nurse at shift change, as she felt the injury was not serious, and that the incident was not of recent occurrence as it had occurred several days before.

Inspector #545 reviewed the home's abuse policy titled "Abuse, Patients, Residents, or Visitors", policy #CLI N CARE 32 with a revision date of 2013-1 0 which was their most recent policy as indicated by the Administrator/Clinical manager. The policy indicated:

8.1 Physical abuse: The use of physical force that is contrary to an individual's health, safety, or well-being and that causes or may cause pain or injury, including but not limited to assault, inappropriate confinement, prohibited or inappropriate restraints, slapping, pinching, forced feeding, or rough handling. Administering or withholding a drug for an inappropriate purpose is also considered physical abuse.

The definition of physical abuse did not clearly set out what constitutes abuse as per s. 2
of the reguiatkms. H did not identify that a physical abuse" means, -
(a) the use of physical force by anyone other than a resident that causes physical injury
or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident;
("mauvais traitement d'ordre physique")

Inspector #545 reviewed the home's abuse policy titled "Abuse, Patients, Residents, or
·visitors", policy #CLI N CARE 32 with a revision date of 2013-1 0 which was their most
recent policy as indicated by the Administrator/Clinical manager. The policy indicated:

4.1 The staff person who witnesses abuse, who believes that a patient or visitor has been or is at risk of being abused, or who is advised by a patient or visitor of abuse

immediately reports the situation to the clinical manager/director of care/delegate, who in turn reports to the program director and the attending physician. {If the abuser is the person to whom one would normally report, report is to be made one level up.) Evening, nights, weekends, stat holidays: The nurse contacts the nursing supervisor (or the Clinical-on-Call if the nursing supervisor is not available), who in turn calls the Administrator-on-Call. The nursing supervisor or Clinical-on-Call advises the clinical manager/director of care on the next regular working day.

4.6 Long Term Care: The Director of Care (evening, nights, weekends, stat holidays: the nursing supervisor/Clinical-on-Call) must immediately report all alleged, suspected, or witnessed abuse to the Ministry of Health and Long Term Care duty inspector (phone: 1- 855-819-0879; e-mail: ciattgeneral.moh@ontario.ca) as required under the Long Term Care Homes Act, along with a description of the steps taken to resolve the situation. {The nursing supervisor/Clinical-on-call notifies the Director of Care by email of any such report that she has made.)

The policy did not contain all the requirements under s. 24 of the L TCH Act. It did not identify that if a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
• Improper or incompetent treatment or care of a resident that resulted in harm or risk of
harm to the resident,
• Unlawful conduct that resulted in harm or a risk of harm to a resident,
• Misuse or misappropriation of a resident's money and
• Misuse or misappropriation of funding provided to a licensee under the L TCH Act or the
Local System Integration Act, 2006.

The policy did not indicate the after- hours MOHL TC contact information.

In discussion with the Clinical Manager TL, she indicated that she was notified of the incident on a specific day of August 2015. She indicated that she conducted an investigation that day, but did not report the alleged physical abuse to the Director. The Clinical Manager stated that the bruises on Resident #019's arms caused by the PCA meet the definition of physical abuse and it should have been immediately reported to the Director.

The Clinical Manager indicated that the home's abuse policy titled "Abuse, Patients,

Residents, or Visitors", policy #CLIN CARE 32 with a revision date of 2013-10, would be updated to reflect the legislation, as staff training was based on this policy. [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 policy is updated and shall clearly set out what constitutes abuse and neglect and shall contain an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that potential abuse of a resident by a staff member that resulted in harm or risk of arm , shall have immediately report the suspicion and the information upon which it was based to the Director.

During an interview with Resident #019 on September 29, 2015, he/she indicated that on a specific day of August 2015 a male PCA held on to his/her arms very tightly while he was drying him/her after giving the bath. The Resident indicated that he/she told the PCA to stop pinching him/her that hard as he/she would bruise. The Resident indicated to the Inspector that a family member encouraged him/her to report the incident to the registered staff after observing bruises on the arms. The Resident reported the alleged
physical abuse to the registered staff three days after the incident and again the next day.

Progress Notes were reviewed by the Inspector.
• A note documented on a specific day of August 2015 indicated that in the evening, Resident #019 reported toRN #S130 that a male PCA had held his/her arms very hard during bath care and had caused bruising. The note indicated that two bruises were observed: bruise on the left arm measured 2.5cm-3cm, and the one on the right arm measured 1 em. The note ends with "Will follow-up".
• A note documented on the next following day of August 2015 indicated that the Resident explained to the night RN how the bruises on his/her arms got there. The note further indicated that support was provided, will continue to monitor.

During an interview with RN S#130, she indicated she remembered the incident when Resident #019 reported how the bruising on his/her arms came upon. RN 8#130 indicated that a physical abuse was defined as damage caused to a person by another person, for exampie hitting them intentionally or by accident running into them with a wheelchair. The RN indicated that she did not notify the nursing supervisor (or the Clinical-on-Call if the nursing supervisor was not available) of the alleged physical abuse
as she had been busy the evening on that specific day of August 2015. She further indicated that she had informed the night nurse at shift change, as she felt the injury was not that serious, and that the incident was not of recent occurrence as it had occurred several days before.

In discussion with the Clinical Manager, she indicated that she was notified of the

alleged physical abuse on a specific day of August 2015. She indicated that she conducted an investigation that day and that the Resident had other concerns at the time that took more of a priority, therefore had not reported the alleged physical abuse to the Director. The Clinical Manager stated that the bruises on Resident #019's arms caused by thePCA met the definition of physical abuse and that the alleged physical abuse shouldhave been immediately reported to the Director.

At the time of leaving the home, the licensee had not notified the Director of the alleged
physical abuse. [s. 24. (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 a person who had reasonable grounds to suspect abuse of a resident that resulted in harm or risk of arm , shall immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible; strategies are developed and implemented to respond to these behaviours, where possible; and that the resident's responses to interventions are documented.

Resident #027 was admitted on a specific day in June 2014 with several medical conditions. On September 30 and October 7, 2015 Inspector #545 observed the Resident to be unshaven, untrimmed nails with several filled with brownish debris as well as bruises on top of both his/her hands.

On the most recent assessment in July 2015, it was documented that Resident #027 had an unpleasant mood in the morning, wandered, was verbally and physically abusive daily, was socially inappropriate and resisted care on a daily basis.

During an interview with PCA #S127 and #126 on October 7, 2015 they indicated that the Resident did not want to get up before noon, and that staff did not force him/her to get up as he could easily become physically abusive towards staff by hitting or punching them. PCA #S 127 indicated that the Resident resisted care and that he/she frequently refused to be shaved or to have his/her nails trimmed and cleaned. PCA #S 127 also indicated that the bruises on his/her hands were not new injuries, and that they were probably caused by the Resident when he/she hits the bed rails or the walker. She further
indicated that the Resident was also known to put his/her hands in his/her soiled brief and that might be the reason for the uncleaned nails. Both PCAs indicated that when the esident refused to get up, they were expected to leave and return later.

During an interview with BSO #S121, the BSO PCA indicated that Resident #027 was known to the Behavioural Support Team. It was also known that the Resident did not like to get up before noon. As the Resident is diabetic, an effective strategy is to give care to the Resident is for staff to tell the Resident it was noon when entering the bedroom at 08:00 and by showing him/her his clothes. With this approach, the Resident usually cooperates, but if he/she doesn't, staff are directed to leave and return· later.

In a review of the recent Plan of Care dated July 2014, it was documented that due to cognitive impairment, interventions by staff were to encourage Resident #027 to participate during care and to provide extra time. Information on Responsive Behaviours for Resident #027 was not found.

During interviews with RPN S#129 and RN RN #106, they indicated that Resident #027's responsive behaviours were not new. They both confirmed that Resident #027 that he/she didn't want to get up before noon, often resisted care and that staff were expected to leave and return later to prevent altercations between the Resident and staff. After reviewing Resident #027's plan of care, they both indicated that the behavioural triggers were not identified, strategies were not developed and implemented to respond to these behaviours; and that the resident's responses to interventions were not documented, for
example refusal to care in the daily flow sheet for 5 days in October 2015 for nail care, shaving and tub bath. [s. 53. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible; strategies are developed and implemented to respond to these behaviours, where possible; and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: 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 has failed to ensure that 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 (e.g. expiration dates, refrigeration, lighting)
Note: This subsection does not apply with respect to drugs that a resident is permitted to keep on his or her person or in his or her room in accordance with subsection 131 (7).

Two Inspectors observed the following medication in the following areas of the home:
Inspector #545:
Two prescribed cream on resident's dresser, one inhaler in a clear plastic bag on the resident's bed table and one medicated shampoo in the spa room.

Inspector #547:
Two prescribed cream observed at the bedside.

The Director of Care/Clinical Manager indicated to Inspector #550 that although her expectation is to have all prescribed lotions and creams kept locked in the medication cart; this is not the reality in the home at this time. She indicated staffs need to be educated to do this and no education was provided to them on this so far. She indicated that at this time the resident's prescribed creams and lotions are kept in the resident's bedroom in their bedside table and the bedside tables are not locked.

The DOC indicated to inspector she is aware of the L TCHA's requirement for medications to be kept in an area or medication cart that is locked at all times, she just has not been around to do this at this time. [s. 129. (1) (a)]

2. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On September 30, 2015 at 08:58, Inspector #545 observed the Medication Cart unlocked and unattended outside the large dining room on the 5th floor. A PSW indicated that the nurse was administrating medications to a Resident inside the Dining Room. The Inspector observed RPN #S 110 sitting on a chair facing a female Resident. The nurse's back was facing the Medication Cart located outside the dining room while she was administrating eye drops, and then administrating puffers via an aerochamber. At 09:05, RPN S#11 0 came out of Dining Room and indicated to the Inspector that her Medication
Cart should have been locked as she was unable to see it while she was in the Dining Room administering medication to a resident.

On September 30, 2015 at 11 :25, Inspector #545 observed a Medication Cart unlocked and unattended in front of the Dining Room on the Dementia Unit. A PCA indicated to the Inspector that RPN #S 111 was at the end of the hallway in front of the Medication Room, administrating medication to a Resident. The nurse's back was facing the Medication Cart. Five minutes later, the RPN arrived by the unlocked

Medication Cart and indicated that she had forgotten to lock her cart when she left it unattended to
administer medications to a Resident at the end of the hallway. She further indicated that
when she left the Medication Cart, she was no longer able to view the cart, as her back
was turned to it. [s. 129. (1) (a) (ii)]

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 ensure that drugs are stored in an area that is secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, that residents were assessed and their bed systems evaluated in accordance with evidence-based practices.

During the Resident Quality Inspection it was observed by Inspectors that several beds mattresses did not fit the bed frame.

The "Adult Hospital Beds: Patient Entrapment Side Rail Latching Reliability, and Other Hazards", Health Canada Guidance Document indicates: "Zone 7 is the space between the inside surface of the head board or foot board and the end of the mattress. This space may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from loosened head or foot .'boards." For the measurement of the head, Health Canada is therefore using a head breadth dimension of 120 mm (4 ¾ inches) as the basis for its dimensional limit recommendations. This dimension is consistent with the dimensions recommended by the Hospital Bed Safety Workgroup (HBSW) and the International Electrotechnical Commission(IEC).

Out of these several beds, three beds were identified to have space greater than 4 3/4 inch between the inside surface of the head board or foot board and the end of the mattress.

On October 2, 2015 Inspector #547 interviewed the home's Maintenance Coordinator and the Administrator regarding the home's process for bed system evaluation for residents who have bed rails used in the home, and they both indicated that the home has approximately four different bed systems in the home and that they do not currently have a bed system evaluation process for residents who use bed rails. [s. 15. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and acquiring, in the case of new items.

On September 29, 2015 Resident #002 indicated to Inspector #547 that he/she lost his/her eye glasses and the family had to buy a new pair. Resident indicated that his/her glasses were not labelled and the new pair were noted to also not labelled.

On October&, 20:~5 .·1nspector #547 interviewed the ward clerk regarding the admission process for labelling residents with glasses, dentures or hearing aids and the ward clerk indicated that the home does not have any method of identifying these items that she was aware of. Inspector #54 7 then interviewed the DOC/Clinical Manager who indicated that the home currently does not have a system in place for labelling or identifying resident's glasses, dentures or hearing aids. [s. 37. (1) (a)]

2. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids, cleaned as required. On September 29-30, 2015, Inspectors #126 and #547 observed the following:

Resident #003 wheelchair, seat and restraint belt were observed to be heavily soiled with dried white matter.

Resident #01 0 electric wheelchair was observed to be soiled with dust and debris to the base of the chair.

Resident #031 walker was observed to be soiled with what appears to be dry food matter.

Resident #035 walker was observed to be soiled with what appears to be dry food

matter.

On October 5, 2015, Inspector #547 interviewed PCA #S113 who indicated that the resident's walkers and wheelchairs used to be cleaned monthly by a company that came in the home. However they are no longer coming in. At this time the PCA are not responsible for cleaning Resident's ambulation equipment.

On October 5, 2015, Inspector #547 interviewed Environmental/Housekeeping Manager who indicated that the housekeeping staffs were not responsible for the resident's personal equipment. If the housekeeping staffs notice a very soiled chair or walker, nothing was stopping them from using a wet cloth with cleaning solution to wipe down the item as required, but there is no formal cleaning routine in the home at this time.

On October 6, 2015, Inspector # 54 7 interviewed RN #S 116 who indicated that when the resident's wheelchairs or walkers are soiled, that they are wiped down by the nursing staff. If they are heavily soiled, the nursing staff notify housekeeping staff.

On October 6, 2015, Inspector #547 interviewed the DOC\Ciinical Manager .regarding the washing of resident's personal care equipment. The DOC\Ciinical Manager indicated that the home had a company come to the home 6 months ago for the deep cleaning of all equipment and that was to occurred twice yearly. The DOC\Ciinical Manager indicated that the home is expecting that daily washing and wiping be done by both PCA's, and housekeeping staff if the equipment is heavily soiled. [s. 37. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During an observation of Resident #018's room on September 29, 2015, Inspector #545 observed Ventolin inhaler with aero chamber in a clear plastic bag on the Resident's bed table.

During an interview, Resident #18 indicated to Inspector #550 he/she self-administers the Ventolin inhaler on his/her own when required and then documents the administrationdate and time on a sheet of paper kept with the medication. Resident# 018 showed inspector he/she keeps the Ventolin inhaler, the aero chamber and the list of administration dates and times in a Ziplock bag on top of the over bed table. Inspector observed that the last date and time of the Ventolin administration documented on the
sheet of paper was October 3, 2015 at 6:30PM. This paper was inside the zip lock bag. Resident #018 indicated this was the last date and time he/she self-administered the Ventolin inhaler.

The Director of Care/Clinical Manager indicated to Inspector #550 that before a resident
can self-administer medication, education has to be done with the resident and then staff need to follow-up to ensure medication are taken. There has to be a physician order and this needs to be discussed at a care conference before the self administration process can begin. Any residents who are permitted to keep medication at bedside are expected to keep the medication in a drawer out of sight.

Inspector #550 reviewed Resident #018's health records and observed a physician's order dated a specific day of June 2015 that indicated the resident could self administer Ventolin inhaler for 1 week. No further order was found related to the resident's ability to self administer the ventolin inhaler. [s. 131. (5)]

Issued on this 17 day of December 2015 (A1)

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

Ministère 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

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JOANNE HENRIE (550) - (A1)

Inspection No. / No de l'inspection : 2015_285126_0035 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-002646-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 17, 2015;(A1)

Licensee / Titulaire de permis : BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET, OTTAWA, ON, K1N-5C8

LTC Home / Foyer de SLD : ÉLISABETH-BRUYÈRE RESIDENCE
75 BRUYERE STREET, OTTAWA, ON, K1N-5C8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Simon Aikinsulie

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To BRUYERE CONTINUING CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. Dining and snack service

Order / Ordre :

(A1)
The licensee shall ensure that the dining service includes:
1) course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident s assessed needs
2) not serving a meal to a resident who requires assistance with eating or drinking until someone is available to provide the assistance required by the resident
The home shall establish a monitoring process to ensure dining service is provided as per above order and implement corrective actions as the issues are identified during the monitoring process.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that Resident #008 and Resident #021 were served course by course. 0. Reg 79/10, s. 73 (1) (8)

At lunch, on October 6, 2015, in between the soup and main course, Resident #008 was observed eating pudding. At 12:27, he/she received the main course. At 12:49, it was noted that the resident was still eating pudding and the uneaten entree remained in front of him/her. Resident #008's care plan was reviewed, and there is no indication that meals are not to be served course by course.

At supper, on October 6, 2015, Resident #021 was served the main course at 17:05. At 17:11, the resident was observed to be eating pudding, and the uneaten entree

was pushed to the side.

2. The licensee has failed to ensure that 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. 0.Reg 79/10,s.73(2)(b)

On October 6, 2015, lunch and supper meal service was observed on the fifth floor which has two dining areas: the Trillium Room (main dining room with seven tables) and the Seguin's Room.

The following observations were made in the Seguin's Room which has three tables for
nine residents.

Resident #045:

At 12:05, Resident #045 was served soup. At 12:07, the resident was sleeping. The resident did not attempt to feed himself/herself. Nine minutes after receiving the soup, at 12:14, a PCA sat and assisted the resident to eat. At 12:29, Resident #045 received the main course and was assisted to eat by PCA, S #114 who then left to assist a resident in the Trilluim Room. At 12:47, Resident #006, who sits at the same table, was heard saying to a student that Resident #045 needs Ensure and apple juice. Resident #045's beverages had not been completed, and the resident did not attempt to drink independently. The student sat and assisted the resident to complete the beverages.

At 17:02, Resident #045 was served the main course and did not attempt to feed himself/herself. At 17:08, PCA, S #133, put Resident #045's fork in the meat. She did not encourage the resident to eat or provide assistance. Resident # 006, who sits at the same table, was heard saying, I thought she was going to help you. Resident #045's table mates (Resident #006 and Resident #018) were heard telling the resident that once he/she took a bite on his/her own, then staff would come and help. The resident took one bite on his/her own with cueing and encouragement from his/her table mates. Resident #018 was heard saying to Resident #045, Use your spoon, that is excellent. At 17:22, twenty minutes after receiving the main course, PCA, S #132 sat and assisted Resident #045 to eat.

According to Resident #045's care plan, he/she is blind and requires staff to describe where the food is on the plate, place all items within reach and assist the resident to eat when needs help.

Resident #003:

At 12:05, Resident #003 was served soup. The resident was seated in the wheel chair which was positioned at an angle, facing away from the table. Resident# 003 did not attempt to feed himself/herself. Five minutes after receiving the soup, at 12:10, a PCA sat and assisted him/her to eat. At 12:27, Resident #003 was served the main course and did not attempt to feed himself/herself. At 12:33, PCA, 8#113 was assisting Resident #017 when the resident's family member arrived and took over assisting the resident.
PCA, S #113 then moved and assisted Resident #003 to eat the main course five minutes after Resident #003 had been served.

At 1705, Resident #003 was served the main course. At 17:08, PCA, S #133 sat to assist the resident. At 17:10, the staff member left to assist Resident #017 at another table. Resident #003 did not attempt to feed himself/herself. The staff member returned and resumed feeding Resident #003 six minutes later when Resident #017 had completed his/her meal.

Resident #008:

At 12:05, Resident #008 was served soup. The resident did not attempt to feed himself/herself and repeatedly said May I have a hot cup of coffee and a drop of milk. Five minutes after receiving the soup, at 12:10, a PCA sat and assisted him/her to eat. At 12:24, it was noted that Resident #008 was eating pudding and drinking coffee. At 1227, the resident was served the main course. At 12:49, it was noted that the resident was eating pudding, and the uneaten entree remained in front of him/her. Assistance was not provided for Resident #008 to eat the main course.

On Resident #008's kardex, there is a hand written notation dated August 20, 2015, indicating that the resident is a feeder.

At the lunch meal on October 6, 2015, there were two PCAs assisting residents in the Seguin's Room and one PCA taking orders and serving the residents in the Seguin's and the Trillium Room, and PCA, S #114 indicated that this was the

common practice. The DOC stated that her expectation was that were two PCAs in the Trillium Room and one PCA in the Seguin's Room during the lunch meal. Four PCA students were also present for part of the lunch meal. [s. 73.]

Given the number of residents affected by the non-compliance described above and the compliance history of the licensee related to O. Reg. s, 73 (1) 8 during the Resident Quality Inspection conducted in September 2014, a Compliance Order is being issued. (126)

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

Jan 25, 2016(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. Menu planning

Order / Ordre :

The licensee shall ensure that the home's menu cycle includes:
1) a snack menu for regular, therapeutic and texture modified diets
2) offering each resident a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner
3) offering each resident a minimum of a snack in the afternoon and evening
4) having the planned menu items offered and available at each meal

The home shall establish a monitoring process to ensure the menu cycle is implemented as per above order and that the home implement corrective actions as the issues are identified during the monitoring process.

Grounds / Motifs :

1.

1. The licensee has failed to ensure that the home's cycle menu includes menus for regular, therapeutic and texture modified diets for snacks. 0. Reg 79/10, s.71 (1)(b)

In interviews with residents, some residents expressed concern regarding not being consistently offered foods and/or fluids between meals and after dinner which prompted an inspection into the snack menu.

In an interview with the Patient Menu Coordinator and the Nutritional Care Manager, it was reported that the home does not currently have a snack menu for regular, therapeutic and texture modified diets. It was reported that in order to receive a regular snack, it must be prescribed for a specific resident by the Registered Dietitian.

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

During interviews with residents, several reported not being offered fluids between meals.

PCA, S #121 stated that on most days a volunteer offers residents juice in the morning She stated that if no volunteer is present, staff are expected to offer the residents a beverage. She stated that time did not permit for this task to be

completed, and a beverage was not offered to residents in the morning if a volunteer did not complete the task.

PCA, S #114 stated that by the time residents have completed their breakfast and are out of the dining room, it is 10:00 so residents were not offered a beverage between breakfast and lunch. She stated that residents' morning intake of beverages came from at breakfast and with medications.

On October 6, 2015, a portion of the afternoon nourishment pass was observed on the fifth floor. On the cart were three containers of regular consistency juice. There was no beverage to accommodate residents who require a thickened liquid consistency. There was no water to be offered to the residents who may have desired it.

The Diet Technician/Food Services Supervisor was interviewed and indicated that the current expectation was to offer all residents a beverage between meals once daily in the afternoon. She stated that residents were to be offered apple juice. She stated that beverages that were prescribed by the Registered Dietitian would be offered to those specific residents in the morning or in the evening after dinner.

3. The licensee has failed to ensure that residents were offered a a minimum of a snack in the afternoon and evening. 0. Reg 79/10, s. 71 (3)(c)

During interviews with residents, several reported not being offered a snack in the afternoon and evening.

The Diet Technician/Food Services Supervisor was interviewed and indicated that the current expectation was to offer all residents a snack once daily in the afternoon. She indicated that for the afternoon snack, residents on regular and soft textured diets were to be offered digestive cookies, and residents on minced and pureed diets were to offered vanilla or greek yogurt, unless a different afternoon snack had been prescribed by the Registered Dietitian. She stated that only snacks prescribed by the Registered
Dietitian would be offered to those specific residents in the evening.

PCA, S#122 was interviewed and stated that not all residents received an afternoon snack. He stated that there were labelled snacks for some residents. On October 6, 2015, S #122 was observed circulating the nourishment cart on the fifth floor,

commencing at approximately 1445. On the cart for snack for all residents on the floor were 1-2 packets of soda crackers, 1-2 packets of melba toast and one container of peach yogurt. The PCA stated that normally there would be a tray in the servery fridge with labelled snacks, but that there was no tray or labelled snacks on that day, therefore only what was on the nourishment cart is what was offered to the residents.

On October 7, 2015, it was noted that in the fifth floor servery there were fifteen labelled snacks to be offered in the evening to residents. The other residents would not be offered an evening snack.

The Patient Menu Coordinator and Nutritional Care Manager were interviewed and stated that residents who indicated to the Registered Dietitian that they wanted a snack, received a labelled snack that was prepared at an off-site location.

4. The licensee has failed to ensure that planned menu items were offered and available at each meal. 0. Reg, s.71(4)

During the course of the inspection, several dining observations were completed on both
floors of the home.

On October 6, 2015, at lunch, tomato and rice soup and cream of potato soup were listed as menu Hems.-The entire lunch meai was observed on the fifth floor, and Resident #017, Resident #021 and Resident #011 who were seated at a table in the Seguin Room were not offered soup. Soup was available and offered to the other six residents in the dining room.

On October 6, 2015 at supper, creamy coleslaw was listed as a menu item. The Dietary Aide, S# 125 showed Inspector #551 an inventory of all of the supper meal items, and creamy coleslaw was not among them. The entire supper meal was observed on the fifth floor, and creamy coleslaw as indicated on the menu was not offered and available.

On October 7, 2015 at breakfast, stewed prunes were listed as a menu item. Dietary Aide, S #115 stated that stewed prunes used to come pre-portioned, but that they have not been available for a while. In an interview with Inspector #545, Resident #016 expressed concern that the stewed prunes were not available. The entire

breakfast meal was observed on the sixth floor, and stewed prunes as indicated on the menu were not offered and available.

On October 6, 2015, it was noted that Resident #003 did not have any beverages at his/her place setting. At 12:10, Resident#003 was provided assistance to eat the soup. At 12:33, Resident #003 was provided assistance to eat the main course, and at 12:44, was served ice cream. At no time during meal service did he/she receive a beverage to drink.Although no specific beverage is indicated on the lunch menu, the beverage cart was noted to contain a variety of beverages. No beverage was offered to Resident #003 at
the lunch meal. Resident #003's kardex was reviewed, and there is no indication that he/she is not to be offered beverages at meal time. [s. 71.]

Given the number of residents affected by the non-compliance described above, the compliance history of the licensee related to O. Reg. 71(1)(b), (3)(b)(c), during the Resident Quality Inspection conducted in September 2014 and the potential risk to the well-being of Residents, a Compliance Order is being issued. (126)

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

Jan 25, 2016(A1)

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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
Toronto ON M5S 2B1
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 17 day of December 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JOANNE HENRIE - (A1)

Service Area Office /
Bureau régional de services : Ottawa