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

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

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

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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
Oct 07, 2016;	2016_450138_0032 (A1)	018795-16, 018796-16, 018797-16	Follow up

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

PAULA MACDONALD (138) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The following report was amended to reflect that WN #7, originally issued in relation to Élisabeth Bruyère Residence's restraint policy, was determined no longer valid and is being revoked. The policy for restraints is applicable to Bruyère Continuing Care which includes but is not limited to Élisabeth Bruyère Residence. It was noted after the inspection that there is reference in the restraint policy that specific physical restraints are not used in long term care.

Issued on this 7 day of October 2016 (A1)

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

Original report signed by the inspector.

Ontario

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

PAULA MACDONALD (138) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 27, 28, 29, 30 and October 2, and 3, 2016.

The purpose of this inspection was to provide a Follow Up Inspection to compliance orders #002, #003, and #004 that were issued during the Resident Quality Inspection conducted in May and June 2016 relating to dining and snack service as well as residents' plan of care.

During the course of the inspection, the inspector(s) spoke with residents, a volunteer, personal care attendants (PCA), housekeeping attendants, a food service attendants (FSA), the Menu Coordinator, a physiotherapy assistant, a physiotherapist, the Administrative Assistant, registered practical nurses (RPN), registered nurses (RN), the Patient Food Services Manager, the Director of Care and Clinical Manager, and the Administrator.

The inspectors also reviewed home policies and supporting documents, observed meal and snack services, reviewed resident health care records, and reviewed menus.

The following Inspection Protocols were used during this inspection:

Dining Observation

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Snack Observation

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

7 WN(s)
5 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 6. (2)	CO #004	2016_330573_0014	138

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. 71. Menu planning

Specifically failed to comply with the following:

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

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

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with section 71.(3)(b) of the regulation in that the licensee failed to ensure that each resident was offered a minimum of a between meal beverage in the morning and afternoon.

On September 27, 2016, Inspector #551 monitored the sixth floor from 0950-1000 hours and from 1020-1045 hours. The Inspector did not observe a pass for beverages mid-morning. According to the snack menu, residents are to be offered milk, a variety of juices and water daily mid-morning.

On September 27, 2016, the afternoon nourishment pass was observed, and it was noted that resident #027, #028 and #048 were in bed. PCA #116 who was offering the nourishment stated that residents who were in bed would not be offered an afternoon beverage.

Residents #036 and #028 who were sitting in the area across from the elevators, and resident #027 who was in the tv lounge were not offered a beverage. Resident #057 who was in a room with visitors and was not offered a beverage.

On September 29, 2016, Inspector #551 monitored the sixth floor from 0955-1110 hours. At 1120 hours it was noted that the residents had been moved to the dining room in preparation for the lunch meal. The inspector did not observe a pass for beverages mid-morning. According to the snack menu, residents are to be offered milk, a variety of juices and water daily mid-morning.

On September 29, 2016, Inspector #551 monitored the sixth floor from 1415-1545 hours. At 1415 hours, it was noted that a volunteer was offering some residents a hot beverage and cookies as part of a Coffee and Cookies program. The volunteer stated that he followed the dietary kardex and did not offer a beverage or snack to residents who were on a texture modified diet or thickened liquids. According to the dietary kardex, this would exclude seven residents.

An organized nourishment pass did not follow. According to the snack menu, residents were to be offered milk, a variety of juices and water and digestive biscuits, fruit cocktail or strawberry apple sauce.

The lack of mid-morning and afternoon beverages to residents on sixth floor was found to be widespread and presents a risk to residents' hydration status, particularly for residents who refuse meals and those residents who are dependent on staff for feeding and drinking.

The licensee has a compliance history relating to section 71 (3) (b) of the regulation as it was issued as part of the RQI in 2014 (Inspection Number 2014_362138_0014) as a Voluntary Plan of Corrective Action (VPC). This section was issued again as part of the RQI in 2015 (Inspection Number 2015_285126_0035) under an order, CO #002, and the order was placed back into compliance on February 29, 2016. This section was issued again as part of the RQI in 2016 (Inspection Number 2016_330573_0014) under an order, CO #003, and the CO is being reissued at this time. [s. 71. (3) (b)]

2. The licensee has failed to comply with section 71.(3)(c) of the regulation in that the licensee failed to ensure that each resident was offered a minimum of a snack in the afternoon.

On September 29, 2016, Inspector #551 monitored the sixth floor from 1415-1545 hours. At 1415 hours, it was noted that a volunteer was offering some residents a hot beverage and cookies as part of a Coffee and Cookies program. The volunteer stated that he followed the dietary kardex but did not offer a beverage or snack to residents who were on a texture modified diet or thickened liquids. According to the dietary kardex, this would exclude seven residents. After serving residents on the sixth floor, the volunteer proceeded to the fifth floor, and returned to the sixth floor at 1505 hours.

An organized nourishment pass did not follow. According to the snack menu,

residents were to be offered milk, a variety of juices and water and digestive biscuits, fruit cocktail or strawberry apple sauce.

According to PCA #122, it is the responsibility of the sole PCA on the unit from 1430-1530 hours to offer the afternoon snack. At the end of her shift at 1530 hours, PCA #101 left the unit without having circulated the snack cart. [s. 71. (3) (c)]

3. The licensee failed to comply with section 71.(4) of the regulation in that the licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

Inspector #138 observed the breakfast services on September 28, 2016. It was noted by the Inspector that the residents who received a pureed texture meal were not offered the full pureed breakfast menu and only offered the hot cereal portion of the meal. Specifically, resident #039 was provided a hot cereal as per the pureed texture menu. The resident finished the cereal and continued to demonstrate signs of hunger. Resident #039 was provided a banana but was not offered any of the additional menu options which included pureed banana bread with syrup, vanilla pureed cottage cheese, and pureed prunes. It was noted that resident #039 has exhibited unintentional weight loss over the last six months, according to weight records.

It was also observed by Inspector #138 at the same breakfast service that resident #027 and resident #028, both who required a pureed texture diet, were only offered the cereal portion at breakfast despite good appetites. Neither of these residents were offered the pureed fruit, pureed banana bread with syrup, or the pureed vanilla cottage cheese. The Inspector noted that both these residents have had undesirable weight loss in the last six months according to weight records.

Inspector #138 observed two other lunch meal services, one on September 27, 2016, and the second on September 28, 2016. It was observed by the inspector that residents on a pureed diet were not offered pureed bread as indicated on the menu serving guide at either of these lunch meal services. Residents on a regular or minced texture diet were not offered the grain serving as indicated on the menu for the lunch meal service on September 27, 2016. The Inspector also observed at both lunch meal services that residents were not offered a choice of water or milk to drink as indicated on the menu. Further, the Inspector also observed at both lunch meal services that residents were only offered one choice of dessert. On September 27, 2016, residents were offered fruit yogurt for dessert and on

September 28, 2016, residents were only offered ice cream. On both occasions, no other choice was offered to residents who refused dessert.

On September 28, 2016, Inspector #551 noted that PCA #103 began circulating the beverage cart at approximately 1030 hours. Residents including #052, #032, #053, #037, #039, #040, #055, #050 and #023 who were sitting across from the elevators and in the tv lounge were provided with apple juice, and one resident was provided with cranberry juice, in 6oz tumblers. Choice was not offered. On the cart were cold juices; water and milk were not on the nourishment cart.

This section of the regulation, O. Reg 79/10, s, 71.(4), was also previously issued during the 2016 Resident Quality Inspection, Inspection Number 2016_330573_0014, as a Voluntary Plan of Corrective Action and is being re-issued again as part of this inspection. [s. 71. (4)]

Additional Required Actions:

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

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 planned menu items are offered and available to residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Findings/Faits saillants :

1. The licensee failed to comply with section 73. of the regulation in that the home

failed to ensure that the home has a dining and snack service that includes the following:

1. A process to ensure that the food service workers and other staff assisting residents are aware of the residents' diets, special needs, and preferences. O. Reg 79/10, s. 73.(1)5.

According to the food service staff, the Diet Type Report, which is sometimes referred to as the dietary kardex, in the unit servery outlines residents' diet requirements. It was noted by the Inspector that the Diet Type Report outlined type/texture/fluid consistency, additional directions, and dietary supplements. It did not, however, outline any resident preferences related to food and fluids, which is especially important for those residents who are not able to communicate preferences themselves.

Inspector #138 observed several meal services on the sixth floor throughout the course of the inspection. It was noted by the Inspector that there were instances when residents were not provided foods and fluids according to the Diet Type Report. Specifically:

On breakfast on September 28, 2016, resident #039 who requires a pureed texture diet was observed to be offered a regular banana by staff. The Inspector reviewed the Diet Type Report and there was no indication on this report that resident #039 had any exceptions to the pureed texture diet including regular bananas as opposed to pureed bananas.

It was also noted at the breakfast service that resident #057 was not offered the greek yogurt as indicated on Diet Type Report.

In addition, the Inspector also observed that residents were not offered the homogenized or skim milk as indicated on the Diet Type Report nor were residents offered the fruit spread as indicated on the Diet Type Report.

At lunch on September 27, 2016, resident #050 was observed to be assisted by PCA #124 with a commercially prepared thickened milk. The Inspector noted that the Diet Type Report indicates that the resident is to receive regular thin fluids and, in addition, that the resident is lactose intolerant and is to receive Lactaid milk. It was noted by the Inspector that the commercially thickened milk product was not lactose free. Further, the list of dietary supplements outlines that resident #050 is

to receive Ensure Plus with meals. This supplement was not provided to the resident at the meal.

Resident #048 was provided a thickened beverage at the beginning of the lunch meal service as thickened fluids was indicated on the Diet Type Report for the resident. During the lunch meal service, Inspector #551 observed a PCA provide resident #048 with a cup of coffee, not thickened, which the resident drank.

In addition, at this lunch meal, it was observed by Inspector #138 that yogurt containing pieces of strawberries was provided to most residents even those residents on a pureed diet including resident #039, resident #050, and resident #055. The menu indicated that the pureed dessert options were pureed mixed berries or vanilla yogurt.

Inspector #138 also observed a second lunch service the following day on September 28, 2016. The Inspector passed by resident #048 at the beginning of the meal service and heard the resident with gurgling noises. The Inspector noticed at that time that resident #048 was provided and had drank regular thin fluids instead of the nector thick fluids indicated on the Diet Type Report. The Inspector spoke with a PCA regarding the thin liquids provided to the resident. The PCA stated that resident #048 is supposed to have thickened fluids and proceeded to provide the resident with thickened fluids. This was the second time that day that the resident was offered thin fluids as Inspector #551 also observed that resident #048 was provided regular apple juice that morning during the mid-morning beverage pass. Inspector #138 reviewed resident #048's plan of care and it had indicated that thickened fluids were provided to the resident to prevent aspiration and choking.

Resident #027 was assisted by RPN #128 at this lunch meal service. PCA #120 had previously told Inspector #138 that resident #027 required honey thick fluids, which are thicker fluids, as the resident can easily cough and choke when eating. The Inspector reviewed the Diet Type Report and noted that the resident was to be provided honey thick fluids. It was observed by the Inspector however that RPN #128 provided the resident with the incorrect fluid consistency and provided the resident thinner, nector thick fluids instead.

Resident #050 was assisted by staff with soup at the beginning of the same lunch meal. A volunteer had then stepped in to assist the resident with the entree portion of the meal. The resident was not provided any other beverage to drink nor was

the resident provided the nutritional supplement that was to be provided according to the supplement list.

It was observed again by Inspector #138 at this lunch meal service that homogenized milk, skim milk, and greek yogurt was not provided to those residents as indicated in the Diet Type Report. One specific example is resident #031. Resident #031 was not provided the greek yogurt or the homogenized milk at the lunch meal service as indicated on the Diet Type Report. The dietitian's quarterly MDS assessment dated September 6, 2016, for resident #031 demonstrates that the resident is underweight, has ongoing weight loss, and a small appetite. The dietitian's intervention is to provide the resident with nutrient dense foods such as homogenized milk.

2. Course by course service of meals for residents, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg 79/10, s. 73.(1)8.

Inspector #138 observed during the lunch meal services on September 27, 2016, and September 28, 2016, that course by course service was not always provided to all residents. For example, resident #023 and resident #036 were provided their soup. The residents were then provided their entree before assistance with the soup was provided. The plans of care were reviewed for resident #023 and #036 and there was no indication that the residents were not to receive course by course service.

It was also noted by the Inspector at the same meal service that desserts were distributed to residents in Pauline's Place dining room, approximately six residents, before the residents had a chance to finish their entree. One another occasion, it was observed that resident #055 was eating the entree portion on the meal when the resident was provided a dessert of ice cream. The resident's ice had melted by the time the resident was ready to eat the dessert. There was no indication on the resident's plan of care that the resident was not to receive course by course service.

3. Proper feeding techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73.(1)10.

At lunch on September 27, 2016, Inspector #138 observed PCA #120 stand while feeding resident #028 soup and then later thickened fluids. Resident #028 receives thickened fluids to prevent choking and aspiration.

At breakfast on September 28, 2016, Inspector #138 observed PCA #120 stand while feeding resident #023 breakfast. Later at lunch that day, the Inspector observed PCA #124 stand while feeding resident #023 and PCA #120 stand while feeding another resident who normally is able to eat independently.

At all meals observed, the inspector observed that resident #048 was positioned poorly during the meal service. The resident was seated in a reclined wheelchair with an over bed table positioned at the resident's feet. It was observed that the distance between the table and the resident was not conducive to independent eating and that the resident appeared to have difficulty to lean forward in an attempt to reach the food that was on the table. The Inspector spoke with several staff regarding the positioning of #048 and the Inspector was told that the resident's wheelchair will not move any further upright. No other attempts to properly position resident #048 were made. Resident #048 was noted to have a low body mass index.

4. No person who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg 79/10, s. 73.(2)(b).

Inspector #138 observed at lunch on September 27, 2016, that resident #023 was provided a soup at 1202 hours and the entree portion several minutes after that. The resident did not eat and assistance was not provided to the resident until twenty-two minutes later.

Also at the same meal service, the Inspector observed that resident #036 had a soup by 1202 hours. The resident did not eat and the entree was provided several minutes later. Again, the resident did not eat until thirty minutes later when assisted by a PCA.

The Inspector spoke with PCA #124 regarding resident #023 and resident #036 abilities to feed themselves. PCA #124 stated that both resident require total assistance with feeding.

The licensee has a compliance history relating to section 73 of the regulation as it was issued as part of the RQI in 2014 (Inspection Number 2014_362138_0014) as a Voluntary Plan of Corrective Action (VPC). This section was issued again as part of the RQI in 2015 (Inspection Number 2015_285126_0035) under an order, CO

#001, and the order was placed back into compliance on February 29, 2016. This section was issued again as part of the RQI in 2016 (Inspection Number 2016_330573_0014) under an order, CO #002, and the CO is being reissued at this time [s. 73.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to comply with section 26.(3)19. of the regulation in that the licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of a resident's safety risks relating to restraints.

Resident #058 was observed by Inspector #138 on September 28, 2016, to be positioned poorly in a wheelchair with a soft padded Posey lap belt applied that had been attached to the rear of the wheelchair. As noted in WN #6, it was identified that the soft padded Posey lap belt had not been observed to be applied according to the manufacturer's directions. Later that same day, the Inspector observed that the resident was still seated in the wheelchair with the soft padded Posey lap belt applied but this time the Inspector noted that the resident had significantly slipped down in the wheelchair with the Posey belt rising from the pelvis area to the resident's mid abdominal area. Inspector #138 spoke with PCA #124 regarding the

positioning of resident #058. PCA #124 stated that the resident frequently slips down the wheelchair regardless of how often the resident is repositioned.

The Inspector spoke with the Director Care and Clinical Manager regarding resident #058. The Director of Care and Clinical Manager stated that she was aware that the resident was slipping in the wheelchair even when the soft padded Posey lap belt was applied and with frequent repositioning. The Director of Care and Clinical Manager stated that the resident was unable to make the purchase of a new wheelchair and therefore the home had to provide a wheelchair from those available in the home. The Director of Care and Clinical Manager stated that the home is currently searching its inventory for a better fitting wheelchair for the resident that will hopefully prevent the resident from slipping.

This led the Inspector to review resident #058's health care record. It was noted in the health care record that the wheelchair with a lap belt as a restraint was initiated in July 2016, with a corresponding physician's order and inclusion into the resident's plan of care. The Inspector continued to review the resident's health care record including the progress notes which outlined that the resident suffered from involuntary movements and that the resident frequently exhibited physical aggression. The Inspector also viewed a specific progress note in August 2016, that indicated the resident had slipped in the wheelchair with the lap belt applied and was found stuck in the wheelchair. The Inspector again spoke with the Director of Care and Clinical Manager regarding this incident and she confirmed that the resident had been found in the wheelchair with the soft padded Posey lap belt applied having slipped enough in the wheelchair that the resident got stuck.

The Inspector then spoke with the home's physiotherapist and a physiotherapy assistant regarding resident #058. Both stated that the home does not involved physiotherapy in the assessment process for the use of restraints. The physiotherapist further stated that she had not been involved in the assessment of resident #058's use of a wheelchair with a lap belt as a restraint, noting that the resident is independent with mobility. The physiotherapist also stated that home does not have its own occupational therapy services for services such as wheelchair assessments and fittings but that occupation therapy services could only be provided privately to the resident or through a referral to the Community Care Access Centre (CCAC).

The Inspector once again reviewed resident #058's health care record and noted that no referral was made to physiotherapy services or to CCAC for occupational

therapy services in July 2016 to provide an assessment related to the initiation of the use of a wheelchair with a lap belt as a restraint, especially given the safety risk of physical aggression and involuntary movements. It was also noted by the Inspector that a referral was not made to either of these services after the resident was observed in August 2016 with an additional safety risk when the resident was discovered stuck in the wheelchair after being seated in the wheelchair with the lap belt applied.

It was noted that at the end of the inspection, resident #058's wheelchair had been switched to a different, smaller wheelchair with an attached lap belt that appeared to fit the resident better. It was also noted that the home initiated a referral to CCAC for occupational therapy services to provide a consultation regarding the current wheelchair with lap belt restraint. [s. 26. (3) 19.]

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 the plan of care related to safety risk with restraints is based on a interdisciplinary assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with section 68 (2) (a) of the regulation in that the licensee failed to ensure that the programs of nutrition care and dietary services and hydration include the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, policies and procedures and systems relating to nutrition care and dietary services and hydration.

The licensee is required to have an organized program of hydration required under clause 11 (1) (b) of the Act that includes the development and implementation of policies and procedures relating to hydration.

As part of CO #003 issued on June 20, 2016 (2016_330573_0014) the licensee was ordered to develop and implement a policy related to hydration that outlines, at a minimum, the types and quantities of fluids to be provided to residents at each meal and snack service, with special consideration to those residents requiring thickened fluids. The compliance date was July 31, 2016.

On September 27, 2016, the lunch meal on the sixth floor was monitored with regards to hydration by Inspector #551. According to the dietary kardex, two residents (#028 and #048) require nectar thick liquids, and one resident (#027) requires honey thick liquids. It was noted that residents #027 and #048 did not receive soup as part of their meal, which according to the home is considered 180ml of fluid. During this meal service, it was further noted that:
- for resident #027, who did not receive a mid-morning beverage, a 250ml tetra pak of nectar thick water was poured into a mug and was thickened with a thickening powder. The resident did not consume the water, and a full mug was observed being discarded at the end of the meal.
- residents #028, who did not receive a mid-morning beverage, received 120ml of thickened juice and one serving of thickened soup for an intake of approximately 400ml fluids.

On September 28, 2016, the lunch meal on the sixth floor was also monitored with regards to hydration by Inspector #551 . It was noted that residents #027 and #048 did not receive soup as part of their meal which as noted above counts as a fluid. It was further observed that:
- resident #028, who did not receive a mid-morning beverage, received 120ml orange juice and one serving of soup.
- resident #027, who did not receive a mid-morning beverage, received 120ml nectar thick cranberry juice and one 250ml tetra pak of nectar thick water. The resident consumed the cranberry juice and the water was added to the same glass. At 1245 hours, it was noted that approximately one quarter of the water was discarded.

On September 29, 2016, the Patient Food Services Manager sent to Inspector #551 two documents titled Guidelines related to Hydration (revision date August 2016) and Hydration Management at EBR (dated September 22, 2016). According to the Patient Food Services Manager the documents were prepared by the Director of Care and Clinical Manager and the Registered Dietitian, respectively.

In a meeting with the Director of Care and Clinical Manager on September 30, 2016, she indicated that these documents would be used to support the development of the hydration policy by the corporate policy developer, and that no actual hydration policy had been developed and implemented as of this date. [s. 68. (2) (a)]

2. According to sections 68.(2)(d), 8.(1), and 30.(1)1 of the regulation, the home is required to have relevant policies that the licensee complies with in respect to a system to monitor and evaluate the food and fluid intake for residents with identified nutrition and/or hydration risks.

Inspector #551 observed several residents with identified risks relating to nutrition and/or hydration during the meal and snack service and reviewed the documentation with regards to fluid intake for these specific residents. The Inspector found that the documentation of food and fluid intakes to be exaggerated for these residents with nutrition and/or hydration risks.

Specifically the food and fluid intake for residents #027, #028 and #048 were monitored as these residents require thickened liquids, and their intake of fluids was observed to be limited.

On September 27, 2016, Inspector #551 monitored the sixth floor from 0950-1000 hours and from 1020-1045 hours. The inspector did not observe a pass for beverages mid-morning.

According to the electronic documentation record in Point of Care (POC), on September 27, 2016 at 1030, resident #28 consumed two (2) servings of fluids and ate 25% of a snack (charted at 1052); resident #27 consumed one (1) serving of fluids and refused a snack (charted at 1058); and resident #048 consumed 1 serving of fluids and consumed 25% of a snack (charted at 0944).

On September 29, 2016, Inspector #551 monitored the sixth floor from 0955-1110 hours. At 1120 hours it was noted that the residents had been moved to the dining room in preparation for the lunch meal. The inspector did not observe a pass for beverages mid-morning. On September 29, 2016, Inspector #551 monitored the sixth floor from 1415-1545 hours and did not observe an afternoon nourishment pass.

Three residents were chosen at random to have their electronic documentation in POC reviewed.

Where the residents were observed to not have received a mid-morning or afternoon nourishment it was documented that on September 29, 2016:

- Resident #028 consumed 1 serving of fluids and 25% of a snack mid-morning

and in the afternoon (charted at 1051 and 1342, respectively).
- Resident #052 consumed 1 serving of fluids mid-morning, and 1 serving of fluids and 25% of a snack in the afternoon (charted at 1045 and 1442, respectively).
- Resident #053 consumed 1 serving of fluids mid-morning, and 1 serving of fluids and 100% of a snack in the afternoon (charted at 1059 and 1334, respectively).

With regards to a system to monitor the food and fluid intake of residents with identified risks related to nutrition and hydration, the Director of Care and Clinical Manager provided copies of 2 policies titled Weight and Height Measurement (clin care 23) and Diet Order Process (clin care 03). The Director of Care and Clinical Manager was not able to produce a policy that addresses the system to monitor the food and fluids intake of residents.

This section of the regulation, O. Reg 79/10, s, 68.(2)(a), was also previously issued during the 2016 Resident Quality Inspection, Inspection Number 2016_330573_0014, as a Voluntary Plan of Corrective Action and is being re-issued again as part of this inspection. [s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home has a policy for monitoring the food and fluid intake and accurate documentation of resident food and fluid intake at meals and snacks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to comply with section 76. (4) of the Act in that the licensee failed to ensure that persons receive retraining.

In accordance with the above section, sections 76. (1) and 76. (2) 1. and 3 of the Act, as well as section 219. (1) of the legislation, the licensee shall provide training and annual retraining to staff in the areas of The Residents' Bill of Rights and the long term care home's policy to promote zero tolerance of abuse and neglect of residents.

Inspector #138 and Inspector #551 were observing a lunch meal service on sixth floor on September 28, 2016, when a noise from the back dining room caught the attention of both Inspectors. Both Inspectors turned to look and observed housekeeping attendant #129 in the back dining room speak inappropriately in the presence of the residents (approximately 5 residents were in this dining room at the time). The incident was diffused and the meal service continued.

Both Inspectors met with the Director of Care and Clinical Manager immediately after the meal service to report the housekeeping attendant's conduct. At that time, Inspector #138 requested the last training completed by the housekeeping attendant related to The Residents' Bill of Rights and any training related to the area of resident abuse. The Director of Care and Clinical Manager consulted with the Supervisor of Environmental Services and Housekeeping and the Director of Learning and Development regarding the training for housekeeping attendant #129 and it was determined that the housekeeping attendant had not received any training related to The Residents' Bill of Rights nor any training related to the area of resident abuse. [s. 76. (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 all housekeeping attendants receive annual training in the area of The Resident Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The license failed to comply with section 110.(1) 1. of the regulations in that the licensee failed to ensure, with respect to the restraining of a resident by a physical device, that staff apply the physical device in accordance with any manufacturer's instructions.

Resident #058 was observed on September 28, 2016, to be positioned poorly in a

wheelchair with a soft padded Posey lap belt applied and attached to the rear of the wheelchair. The Inspector monitored the resident throughout the inspection and noted that the soft padded Posey lap belt was applied to the resident but attached to the rear of the wheelchair in different configurations each day. This resident was observed several times to be slipping in wheelchair while the soft padded Posey lap belt was applied.

Resident #057 was observed on September 27, 2016, to be seated in a wheelchair with a soft padded Posey lap belt applied and tied at the rear of the wheelchair. Each day, the resident was observed in a wheelchair with the soft padded Posey lap belt applied but, as with Resident #058 above, each day it was tied in different configurations at the rear of the wheelchair.

The Inspector spoke with the Director of Care and Clinical Manager several times throughout the inspection regarding the soft padded Posey lap belt as a restraint. The Director of Care and Clinical Manager stated that these are approved restraints in the home and confirmed to the Inspector that the soft padded Posey lap belts used by resident #57 and resident #58 were those identified in the home's restraint policy. Inspector #138 obtained a copy of the home's policy regarding restraints, Restraint Minimization with a review date of 2013-11. This policy outlined that the soft padded Posey lap belt is an approved restraint for the home and further provided a web link to obtain manufacturer's instructions. The Inspector obtained the manufacturer's instructions for the soft padded Posey lap belts used in the home and reviewed these manufacturer's instructions. It was noted by the Inspector that the soft padded Posey lap belts applied to resident #057 and resident #058 were not applied according to the manufacturer's instructions at any time during the inspection. [s. 110. (1) 1.]

2. The licensee failed to comply with section 110.(1) 2. of the regulations in that the licensee failed to ensure, with respect to the restraining of a resident by a physical device, that the physical device is well maintained.

Inspector #138 observed resident #045 to be seated in a wheelchair with a soft padded Posey lap belt applied. On October 3, 2016, the Inspector noted that the resident was sitting in a wheelchair in the lounge without any type of lap belt applied. This was again the observation the following day on October 4, 2016. The Inspector reviewed the plan of care for resident #045 and noted that the plan of care outlined that resident #045 was to have lap table with a buckle or lap belt applied as a restraint when up in a wheelchair.

The Inspector further observed resident #045 later in the day on October 4, 2016, and noted that the resident had a lap table attached to the wheelchair. The Inspector spoke with PCA #101 and PCA #123 regarding this observation. PCA #101 stated that Resident #045 will break the lap belts and had broken the last lap belt so that it could not be used. PCA #101 further stated that resident #045's lap table was also broken but that she had attached it the best she could. The Inspector then approached resident #045 along with PCA #101 who demonstrated how she had applied the lap table. It was noted by the Inspector that there was no lap belt applied to resident #045 at the time. The Inspector also noted that the lap table had been applied but that the left side strap and buckle of the lap table was wound around the rear of the wheelchair frame while the right side strap and buckle was missing, resulting in an unsecured restraint.

The Inspector brought the observation forward to the Director of Care and Clinical Manager who stated that it was common for resident #045 to break the restraints that were applied. [s. 110. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that physical device used for restraining is applied according to the manufacturer's instructions and are well maintained, to be implemented voluntarily.

(A1)
The following Non-Compliance has been Revoked: WN #7

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Issued on this 7 day of October 2016 (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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
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Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : PAULA MACDONALD (138) - (A1)

Inspection No. / No de l'inspection : 2016_450138_0032 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 018795-16, 018796-16, 018797-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Oct 07, 2016;(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 : Melissa Donskov

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

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)

Linked to Existing Order / Lien vers ordre existant: 2016_330573_0014, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

1. The licensee shall ensure that each resident, including those residents requiring thickened fluids, is offered a minimum of a between meal beverage in the morning and the afternoon.

2. The licensee shall ensure that each resident is offered a minimum of a snack in the afternoon.

3. The licensee will continue to develop and then implement a policy related to hydration that offers, at a minimun, the types and quantities of fluids to be provided to residents at each meal and snack service, with special consideration to those residents requiring thickened fluids.

Grounds / Motifs :

1. The licensee has failed to comply with section 71.(3)(b) of the regulation in that the licensee failed to ensure that each resident was offered a minimum of a between meal beverage in the morning and afternoon.

On September 27, 2016, Inspector #551 monitored the sixth floor from 0950-1000 hours and from 1020-1045 hours. The Inspector did not observe a pass for beverages mid-morning. According to the snack menu, residents are to be offered milk, a variety of juices and water daily mid-morning.

On September 27, 2016, the afternoon nourishment pass was observed, and it was noted that resident #027, #028 and #048 were in bed. PCA #116 who was offering the nourishment stated that residents who were in bed would not be offered an afternoon beverage.

Residents #036 and #028 who were sitting in the area across from the elevators, and resident #027 who was in the tv lounge were not offered a beverage. Resident #057 who was in a room with visitors and was not offered a beverage.

On September 29, 2016, Inspector #551 monitored the sixth floor from 0955-1110 hours. At 1120 hours it was noted that the residents had been moved to the dining room in preparation for the lunch meal. The inspector did not observe a pass for beverages mid-morning. According to the snack menu, residents are to be offered milk, a variety of juices and water daily mid-morning.

On September 29, 2016, Inspector #551 monitored the sixth floor from 1415-1545 hours. At 1415 hours, it was noted that a volunteer was offering some residents a hot beverage and cookies as part of a Coffee and Cookies program. The volunteer stated that he followed the dietary kardex and did not offer a beverage or snack to residents who were on a texture modified diet or thickened liquids. According to the dietary kardex, this would exclude seven residents.

An organized nourishment pass did not follow. According to the snack menu, residents were to be offered milk, a variety of juices and water and digestive biscuits, fruit cocktail or strawberry apple sauce.

The lack of mid-morning and afternoon beverages to residents on sixth floor was found to be widespread and presents a risk to residents' hydration status, particularly for residents who refuse meals and those residents who are dependent on staff for feeding and drinking.

The licensee has a compliance history relating to section 71 (3) (b) of the regulation as it was issued as part of the RQI in 2014 (Inspection Number 2014_362138_0014)

as a Voluntary Plan of Corrective Action (VPC). This section was issued again as part of the RQI in 2015 (Inspection Number 2015_285126_0035) under an order, CO #002, and the order was placed back into compliance on February 29, 2016. This section was issued again as part of the RQI in 2016 (Inspection Number 2016_330573_0014) under an order, CO #003, and the CO is being reissued at this time. (551)

2. The licensee has failed to comply with section 71.(3)(c) of the regulation in that the licensee failed to ensure that each resident was offered a minimum of a snack in the afternoon.

On September 29, 2016, Inspector #551 monitored the sixth floor from 1415-1545 hours. At 1415 hours, it was noted that a volunteer was offering some residents a hot beverage and cookies as part of a Coffee and Cookies program. The volunteer stated that he followed the dietary kardex but did not offer a beverage or snack to residents who were on a texture modified diet or thickened liquids. According to the dietary kardex, this would exclude seven residents. After serving residents on the sixth floor, the volunteer proceeded to the fifth floor, and returned to the sixth floor at 1505 hours.

An organized nourishment pass did not follow. According to the snack menu, residents were to be offered milk, a variety of juices and water and digestive biscuits, fruit cocktail or strawberry apple sauce.

According to PCA #122, it is the responsibility of the sole PCA on the unit from 1430 -1530 hours to offer the afternoon snack. At the end of her shift at 1530 hours, PCA #101 left the unit without having circulated the snack cart. (551)

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

Nov 30, 2016

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_330573_0014, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the dining and snack service includes:

1. A process to ensure that food service workers and staff assisting residents are aware of the residents' diets, special needs, and preferences so that residents receive the correct diets, planned specials, and menu items in accordance with resident likes and dislikes.

2. Course by course service of meals for all residents unless otherwise indicated in the plan of care.

3. Proper feeding techniques to assist residents with eating, including safe positioning of residents who require assistance.

4. No person who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident.

Grounds / Motifs :

1. The licensee failed to comply with section 73. of the regulation in that the home failed to ensure that the home has a dining and snack service that includes the following:

1. A process to ensure that the food service workers and other staff assisting residents are aware of the residents' diets, special needs, and preferences. O. Reg 79/10, s. 73.(1)5.

According to the food service staff, the Diet Type Report, which is sometimes referred to as the dietary kardex, in the unit servery outlines residents' diet requirements. It was noted by the Inspector that the Diet Type Report outlined type/texture/fluid consistency, additional directions, and dietary supplements. It did not, however, outline any resident preferences related to food and fluids, which is especially important for those residents who are not able to communicate preferences themselves.

Inspector #138 observed several meal services on the sixth floor throughout the course of the inspection. It was noted by the Inspector that there were instances when residents were not provided foods and fluids according to the Diet Type Report. Specifically:

On breakfast on September 28, 2016, resident #039 who requires a pureed texture diet was observed to be offered a regular banana by staff. The Inspector reviewed the Diet Type Report and there was no indication on this report that resident #039 had any exceptions to the pureed texture diet including regular bananas as opposed to pureed bananas.

It was also noted at the breakfast service that resident #057 was not offered the greek yogurt as indicated on Diet Type Report.

In addition, the Inspector also observed that residents were not offered the homogenized or skim milk as indicated on the Diet Type Report nor were residents offered the fruit spread as indicated on the Diet Type Report.

At lunch on September 27, 2016, resident #050 was observed to be assisted by PCA #124 with a commercially prepared thickened milk. The Inspector noted that the Diet Type Report indicates that the resident is to receive regular thin fluids and, in addition, that the resident is lactose intolerant and is to receive Lactaid milk. It was noted by the Inspector that the commercially thickened milk product was not lactose free. Further, the list of dietary supplements outlines that resident #050 is to receive Ensure Plus with meals. This supplement was not provided to the resident at the

meal.

Resident #048 was provided a thickened beverage at the beginning of the lunch meal service as thickened fluids was indicated on the Diet Type Report for the resident. During the lunch meal service, Inspector #551 observed a PCA provide resident #048 with a cup of coffee, not thickened, which the resident drank.

In addition, at this lunch meal, it was observed by Inspector #138 that yogurt containing pieces of strawberries was provided to most residents even those residents on a pureed diet including resident #039, resident #050, and resident #055. The menu indicated that the pureed dessert options were pureed mixed berries or vanilla yogurt.

Inspector #138 also observed a second lunch service the following day on September 28, 2016. The Inspector passed by resident #048 at the beginning of the meal service and heard the resident with gurgling noises. The Inspector noticed at that time that resident #048 was provided and had drank regular thin fluids instead of the nector thick fluids indicated on the Diet Type Report. The Inspector spoke with a PCA regarding the thin liquids provided to the resident. The PCA stated that resident #048 is supposed to have thickened fluids and proceeded to provide the resident with thickened fluids. This was the second time that day that the resident was offered thin fluids as Inspector #551 also observed that resident #048 was provided regular apple juice that morning during the mid-morning beverage pass. Inspector #138 reviewed resident #048's plan of care and it had indicated that thickened fluids were provided to the resident to prevent aspiration and choking.

Resident #027 was assisted by RPN #128 at this lunch meal service. PCA #120 had previously told Inspector #138 that resident #027 required honey thick fluids, which are thicker fluids, as the resident can easily cough and choke when eating. The Inspector reviewed the Diet Type Report and noted that the resident was to be provided honey thick fluids. It was observed by the Inspector however that RPN #128 provided the resident with the incorrect fluid consistency and provided the resident thinner, nector thick fluids instead.

Resident #050 was assisted by staff with soup at the beginning of the same lunch meal. A volunteer had then stepped in to assist the resident with the entree portion of the meal. The resident was not provided any other beverage to drink nor was the resident provided the nutritional supplement that was to be provided according to the

supplement list.

It was observed again by Inspector #138 at this lunch meal service that homogenized milk, skim milk, and greek yogurt was not provided to those residents as indicated in the Diet Type Report. One specific example is resident #031. Resident #031 was not provided the greek yogurt or the homogenized milk at the lunch meal service as indicated on the Diet Type Report. The dietitian's quarterly MDS assessment dated September 6, 2016, for resident #031 demonstrates that the resident is underweight, has ongoing weight loss, and a small appetite. The dietitian's intervention is to provide the resident with nutrient dense foods such as homogenized milk.

2. Course by course service of meals for residents, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg 79/10, s. 73.(1)8.

Inspector #138 observed during the lunch meal services on September 27, 2016, and September 28, 2016, that course by course service was not always provided to all residents. For example, resident #023 and resident #036 were provided their soup. The residents were then provided their entree before assistance with the soup was provided. The plans of care were reviewed for resident #023 and #036 and there was no indication that the residents were not to receive course by course service.

It was also noted by the Inspector at the same meal service that desserts were distributed to residents in Pauline's Place dining room, approximately six residents, before the residents had a chance to finish their entree. One another occasion, it was observed that resident #055 was eating the entree portion on the meal when the resident was provided a dessert of ice cream. The resident's ice had melted by the time the resident was ready to eat the dessert. There was no indication on the resident's plan of care that the resident was not to receive course by course service.

3. Proper feeding techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73.(1)10.

At lunch on September 27, 2016, Inspector #138 observed PCA #120 stand while feeding resident #028 soup and then later thickened fluids. Resident #028 receives thickened fluids to prevent choking and aspiration.

At breakfast on September 28, 2016, Inspector #138 observed PCA #120 stand

while feeding resident #023 breakfast. Later at lunch that day, the Inspector observed PCA #124 stand while feeding resident #023 and PCA #120 stand while feeding another resident who normally is able to eat independently.

At all meals observed, the inspector observed that resident #048 was positioned poorly during the meal service. The resident was seated in a reclined wheelchair with an over bed table positioned at the resident's feet. It was observed that the distance between the table and the resident was not conducive to independent eating and that the resident appeared to have difficulty to lean forward in an attempt to reach the food that was on the table. The Inspector spoke with several staff regarding the positioning of #048 and the Inspector was told that the resident's wheelchair will not move any further upright. No other attempts to properly position resident #048 were made. Resident #048 was noted to have a low body mass index.

4. No person who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg 79/10, s. 73.(2)(b).

Inspector #138 observed at lunch on September 27, 2016, that resident #023 was provided a soup at 1202 hours and the entree portion several minutes after that. The resident did not eat and assistance was not provided to the resident until twenty-two minutes later.

Also at the same meal service, the Inspector observed that resident #036 had a soup by 1202 hours. The resident did not eat and the entree was provided several minutes later. Again, the resident did not eat until thirty minutes later when assisted by a PCA.

The Inspector spoke with PCA #124 regarding resident #023 and resident #036 abilities to feed themselves. PCA #124 stated that both resident require total assistance with feeding.

The licensee has a compliance history relating to section 73 of the regulation as it was issued as part of the RQI in 2014 (Inspection Number 2014_362138_0014) as a Voluntary Plan of Corrective Action (VPC). This section was issued again as part of the RQI in 2015 (Inspection Number 2015_285126_0035) under an order, CO #001, and the order was placed back into compliance on February 29, 2016. This section was issued again as part of the RQI in 2016 (Inspection Number

2016_330573_0014) under an order, CO #002, and the CO is being reissued at this time (138)

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

Nov 30, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 7 day of October 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD - (A1)

Service Area Office /
Bureau régional de services : Ottawa