Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 26, 2013	2013_190159_0016	H-002212-12 H-000371-13	Follow up

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF ERIN MEADOWS
2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 21, 24, 25, 26, 27, 28, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Food Service Manager, Registered Dietitian, Registered nursing staff, Personal Care Aides(PCA), dietary staff and residents.

During the course of the inspection, the inspector(s) reviewed residents health records, home's policies and procedures, observed dining program,observed care and services provided to the residents.

The following Inspection Protocols were used during this inspection:
Dining Observation

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 1.The home's policy and procedure " Nutrition and Hydration" dated April 2013 stated: PCAs would take note of the meal each resident is served, as well as the total amount of fluids served to each resident. This will ensure accurate documentation. PCAs will complete the Nutrition and Hydration Flow Sheet in the dining room immediately following each resident meal to accurately record the amount of foods and fluids consumed by each resident. Nutrition and Hydration Flow sheets reviewed on 3 home areas for April, May and June 2013 identified the flow sheets for multiple residents (Resident #0002, Resident # 0003, Resident #0004, Resident #0005, Resident # 0006, Resident #0007 and Resident #0008) in each home area have inconsistent documentation for intake of food and fluid at meal time and nourishment pass. Several residents had not food and fluid recorded for meals and nourishments. The food and fluid intake records were incomplete and inaccurate. Interview with the Director of Care, nursing staff, and the Food Service Supervisor confirmed that the nutrition and hydration intake records were incomplete. [s. 8. (1) (b)]

2. The Home's policy and procedure for nutrition and hydration revised April 2013 – TAB 07-24 stated the extra fluids consumed by the resident will be documented by the RPN/RN at medication pass on the Daily Additional Fluids Chart. Nutrition and Hydration Flow Sheets will be tallied by the night PCA team which will include the Daily Additional Fluids Charts.
The Daily Additional Fluid Charts were reviewed on 2 home areas for June 2013 identified the additional fluid charts for multiple residents in each home area have inconsistent documentation for extra fluids intake. The extra fluids intake of resident was not recorded on June 6, 2013, June 16, 2013 and June 24, 2013. Several residents had not fluids intake recorded on the nutrition and hydration flow sheets. The Registered Practical Nurse stated for totaling the resident intake for 24 hour period, extra fluids consumed by the resident should be documented on the Daily Additional Fluids Chart prior to transcribing on the nutrition and hydration intake flow sheets. [s. 8. (1) (b)]

3. The home's policy and procedure for "Hydration Therapy" last reviewed June 2013 stated "monitor insertion site and infusion rate every 4 hours and as required. Record input on the "Hydration Form". The Registered Practical Nurse and the Food Service Supervisor confirmed the total amount of intravenous fluid infused over 24 hours should be recorded on the nutrition and hydration flow sheets prior to totaling the resident fluid input for the 24 hour period.
The policy and procedure was not complied for resident #0004. The plan of care for

the resident stated resident received treatment. Resident's documentation of fluid on the treatment form was reviewed for May, 2013 and June 2013 and fluid infused was not consistently recorded. The fluid intake recorded on the nutrition and hydration flow sheets and on the treatment form did not consistently match in total amount of fluids consumed for each 24 hour period. The resident's plan of care stated the resident was to receive 1450ml fluids per day. The documentation on the nutrition and hydration intake flow sheets indicated the resident did not receive the required amounts of fluids for each of 14 days in June 2013. [s. 8. (1) (b)]

4. The policy and procedure for treatment was not complied for Resident#0005. The resident's plan of care stated resident received treatment as required. The resident's documentation of fluid intake was reviewed for June 2013. Daily Additional Fluids Chart and the Nutrition and Hydration flow sheets did not match in total amounts of fluids consumed for each 24 hour period. The documentation on the nutrition and hydration flow sheets indicated the resident did not receive the required volume of fluids for each 15 consecutive days. [s. 8. (1) (b)]

5. The Policy and Procedure "Hydration"Tab 07-24 No.2 indicated the RPN will assess signs and symptoms of dehydration. If the resident exhibits signs and symptoms of dehydration, ensure the request for Nutrition Consultation has been initiated. If the resident is consuming less than 1,000ml fluids/day for three consecutive days, notify the physician.
Resident #0006 plan of care identified resident at risk for dehydration due to insufficient fluid intake. A review of the fluid monitoring Nutrition and Hydration flow sheets indicated that the resident consumed less than 1,000ml fluids/day, for 3 consecutive days. The Registered Practical Nurse and the RAI Coordinator confirmed that the referral for nutrition consultation was not initiated and the physician was not notified. Registered dietitian interview further confirmed that the referral for nutrition consultation was not made. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. Staff did not collaborate with each other in the assessment of resident # 0005 so that their assessments were integrated, consistent and complemented each other in relation to resident's poor fluid consumption. A Minimum Data Set (MDS) full assessment completed for resident #0005 January 2013 indicated that the Resident Assessment Protocol related to hydration and malnutrition problem will be care planned with the goal of improving. The documentation on the progress notes and the interview with Resident Instrument (RAI) Coordinator confirmed that the Resident Assessment Protocol (RAP) # 14:14- Dehydration and # 12:12 Malnutrition were triggered. The Resident Instrument (RAI) Coordinator confirmed that the Dehydration RAP triggered due to Urinary Tract Infection (UTI) was addressed by the nursing staff, however, the RAP triggered for Malnutrition and Dehydration were not completed by the registered dietitian. The next MDS full assessment completed April 2013 indicated the resident had further decline in nutritional and hydration status and resulted a significant unplanned weight loss and risk for dehydration. The RAI Coordinator confirmed that a RAP assessment related to dehydration and malnutrition was not completed by the dietitian. [s. 6. (4) (a)]

2. The plan of care for Resident #0003 indicated the resident be provided double portion of protein at lunch and dinner, however, resident was served regular portion of entrée at lunch. A Private Care Aide (PCA) was observed assisting the resident with eating. The lunch meal served to the resident consisted of cream of soup, pureed chicken, pureed bread, pureed salad. Resident was served regular portion of entrée (pureed chicken). The staff person (PCA) interview stated that the dietary staff served regular portion of entrée. The plan of care dated April 2013 identified the Registered Dietitian (Hospital) had recommended resident to receive two protein at breakfast and double protein portion at lunch and dinner. Minimum Data Set (MDS) full assessment completed April 2013 the resident was identified as a high risk for meeting the nutritional requirement due to medical diagnosis. [s. 6. (7)]

3. Resident #0007 plan of care dated June 2013 stated resident be provided double portion at each meal. The resident was observed by the inspector in the dining room, resident received full pureed meal with regular portions of entrée, bread and salad. Nutritional Risk Screen Quarterly assessment completed April 2013 identified the resident has a history of gradual weight loss, insufficient food and fluid intake. The resident did not receive double portions of entree, vegetable and dessert. [s. 6. (7)]

4. Resident #0004 did not receive care as specified in the plan of care related to fluid

requirement. The plan of care stated fluid plan as 250ml water at all meal and 175 ml hot beverage. On June 26, 2013 the resident received try service, the fluids served were thickened milk 125 ml, thickened water 125ml and 125 thickened apple juice, hot beverage was not offered. The private care aide assisting resident with eating confirmed the resident was to receive hot beverage and 250ml honey thickened water. The resident's progress notes and the plan of care identified resident received treatment due to insufficient fluid intake. Resident did not receive the fluids and the amounts as specified in the plan of care. [s. 6. (7)]

5. Resident # 0005 was ordered by the attending physician to receive treatment as necessary to supplement fluids if the resident did not consume 1400cc per 24 hours. The Registered Practical Nurse (RPN) confirmed that this order would be implemented if the resident had not consumed 1400 cc of fluid for three consecutive days. A review of the fluid monitoring records indicated that most days the resident consume less than 1000 ml fluids a day. The resident did not consume 1400ml fluids per 24 hour period for 8 consecutive days and interventions were not initiated as directed by the attending physician. [s. 6. (7)]

6. Resident #0002 identified as experiencing a gradual unplanned weight loss was not reassessed and the plan of care not reviewed and revised to address the weight change. Noted at the January 2013 quarterly review the resident had a goal to maintain weight within goal weight range (GWR. The progress notes dated May 2013 documented by the registered dietitian identified the current weigh was below the goal weight. The resident had a 7% weight loss April 2013 to June 2013, however, action was not taken and out comes were not evaluated in relation to the goal for weight maintenance within a goal weight range. The interventions were not reassessed and strategies were not planned to address the weight loss. [s. 6. (11) (b)]

7. The plan of care dated June 2013 for Resident #0004 related to risk for dehydration was not reviewed and revised to ensure that the different approaches were included in the revision of the plan when resident was reassessed on May 2013. The progress notes and interview with the dietitian and the nursing staff confirmed that the resident was at high risk for dehydration due to insufficient fluid intake. The registered dietitian's notes dated May 2013 stated that a referral was made to assess resident's inconsistent fluid intake. The dietitian stated that the resident's fluid intake was 1,000-1,100 ml/day and was below 1200cc/day and not meeting the assessed fluid requirement of 1450ml/day. The plan was to continue with the current hydration plan

in place and no change. The resident was identified be on prolonged use of treatment due insufficient fluid intake. The plan of care for the resident related to dehydration and fluid maintenance was not revised and did not include intervention and strategies related to minimizing risk for dehydration. Nutrition and hydration interventions were not evaluated for effectiveness in relation to the assessed fluid requirement. [s. 6. (11) (b)]

8. The plan of care for Resident #0005 was not revised and different approaches were not considered when care set out in the plan not effective in relation to risk for dehydration. The plan of care included a requirement for the resident's daily fluid intake 1400 mls/day, however, food and fluid intake documentation reviewed for 3 month period (March, April, May, 2013), reflected the resident was consuming less than 1,000ml fluids/day. The registered dietitian completed RAP assessment June 2013, however, did not include an evaluation of resident's fluid consumption and effectiveness of intervention in relation to insufficient fluid intake. The plan of care was not revised and did not include strategies/intervention to mitigate dehydration risk. Review of the progress notes and interview with the dietitian confirmed that nutrition and hydration assessment was not completed. The plan of care identified resident received treatment due to insufficient fluid consumption.

5.The plan of care for Resident #005 was not revised and different approaches were not considered when care set out in the plan not effective in relation to unplanned significant gradual weight loss (Low Body Mass Index). May 2013 the progress notes indicated the registered dietitian received a referral regarding weight loss of 3.3kg over one month period (April to May 2013). The documented notes stated " Current weight was below the Goal Weight Range (GWR). The dietitian reviewed the nutrition hydration flow sheets for April 2013 and clarified the resident diet order, however, there was not re-assessment of the resident in relation to weight loss and the evaluation of interventions that had been implemented in May 2011. The registered dietitian had stated the plan was to continue with the current nutrition plan. The resident was noted to be eating poorly and often refusing fluids (as per progress notes and nutrition and hydration flow sheets and nursing staff interview). The interventions were not evaluated for effectiveness in relation to the goal weight for the prevention of further weight loss. [s. 6. (11) (b)]

9. Resident #0006 plan of care identified resident at risk for dehydration due to insufficient fluid intake. A review of the fluid monitoring Nutrition and Hydration flow

sheets indicated that the resident consumed less than 1,000ml fluids/day, for 3 consecutive days. The Registered Practical Nurse and the RAI Coordinator confirmed that the referral for nutrition consultation was not initiated and the physician was not notified. Registered dietitian interview further confirmed that the referral for nutrition consultation was not made. [s. 6. (11) (b)]

10. The plan of care for Resident #0008 was not revised and different approaches were not considered when care set out in the plan of care not effective in relation to insufficient fluid intake. A review of the resident's Nutrition and Hydration record for May 2013 and June 2013 indicated most days resident consumed less than 1,000ml fluids a day. The plan of care dated June 2013 identified estimated fluid requirement 2250ml fluids/day.
The progress notes dated June 2013 identified that the registered dietitian received a referral regarding resident's insufficient fluid intake. The registered dietitian's documented notes stated "based on current weight fluid requirement is 2200mlfluids/day. Reviewed hydration flow sheet (June/13) fluid intake is variable from 800-1400, 1700ml/day). Resident is meeting fluid needs. No signs and symptoms of dehydration noted. No change." The registered dietitian had identified resident's inconsistent fluid intake and not meeting the assessed fluid requirement over 24 hour period, however, the interventions were not evaluated and different approaches were not taken in the revision of the plan to address the concerns identified related insufficient fluid intake and risk for dehydration. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 002, 003 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. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the production system are prepared, stored and served using methods to: (a) preserve taste, nutritive value, appearance and food quality.
1.The consistency of the pureed food served at lunch to resident on June 24, 2013 and June 26, 2013 was runny on the plate and did not preserve nutritive value, appearance and food quality. The runny pureed entrée (protein) diluted with excessive liquid, not only resulting in reduced nutritive value, altered taste, appearance but also compromises food quality.
2.Staff assisting Resident # 0004 with eating was observed mixing the resident's pureed food items together on the plate. The food was not served in a way that preserved the taste of each menu item and the appearance of the food. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids in the production system are prepared, stored and served using methods to: (a) preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Sufficient time for every resident to eat at his or her pace was not provided as evidenced by:
During the meal service observation on June 24, 2013 Resident# 0009, # 0010, #0011,# 0012, #13 were fed first course soup at 1215 hour and these resident waited for more one hour for the main course to be served and/or fed. Most of these residents were fed their main course in less than 10 minutes. The residents were not given sufficient time to eat specially residents who were having difficulties eating due cognitive impairment. [s. 73. (1) 7.]

2. Resident # 0014 was not provided the level of personal assistance as required to safely eat and drink as comfortably and independently as possible at the lunch meal June 24, 2013.
During the noon meal serve observation resident was served food at 1215 hours and was not eating. After a lengthy period of time a staff member reminded the resident to eat and placed a sandwich in hand. The staff person left the table and went to serve tea/coffee to other residents. The resident was noted to pick the crust off the bread but was not eating and barley touched the meal. The resident required constant encouragement and supervision to eat independently, however, staff did not provided any further encouragement or assistance as a result resident did not consume food and fluids. [s. 73. (1) 9.]

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 sufficient time for every resident to eat at his or her space is provided, to be implemented voluntarily.

WN #5: 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. Weight monitoring system was not in place to measure and record resident # 0004's weight on monthly basis. Resident #0004 did not have weight taken or recorded for the month of January 2013, May 2013 and June 2013. [s. 68. (2) (e)]

2. Resident#0003 did not have weight taken and recorded for the month of May 2013. [s. 68. (2) (e) (i)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

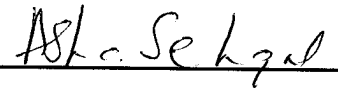
Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (3)	CO #004	2012_026147_0013	159
O.Reg 79/10 s. 26. (4)	CO #003	2012_026147_0013	159

Issued on this 22nd day of August, 2013

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



Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ASHA SEHGAL (159)
Inspection No. / No de l'inspection :	2013_190159_0016
Log No. / Registre no:	H-002212-12 H-000371-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 26, 2013
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF ERIN MEADOWS 2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anneliese Krueger

To OAKWOOD RETIREMENT COMMUNITIES 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: 2012_026147_0013, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the home's policy " Hypodermoclysis treatment and Nurition and Hydration" is complied with, to accurately and consistently document all residents' intake of food and fluid. The plan is to be submitted electronically to Long -Term Care Homes Inspector Asha Sehgal @ Ontario.ca by August 15, 2013.

Grounds / Motifs :

1. The Licensee did not ensure where the Act or Regulation required the licensee of a long-term care home to have institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system is complied with.

1. The home's policy and procedure " Nutrition and Hydration" dated April 2013 stated: PCAs would take note of the meal each resident is served, as well as the total amount of fluids served to each resident. This will ensure accurate documentation. PCAs will complete the Nutrition and Hydration Flow Sheet in the dining room immediately following each resident meal to accurately record the amount of foods and fluids consumed by each resident.
a) Nutrition and Hydration Flow sheets reviewed on 3 home areas for April, May and June 2013 identified the flow sheets for multiple residents (Resident #0002, Resident # 0003, Resident #0004, Resident #0005, Resident # 0006, Resident

#0007 and Resident #0008) in each home area have inconsistent documentation for intake of food and fluid at meal time and nourishment pass. Several residents had no food and fluid recorded for meals and nourishments. The food and fluid intake records were incomplete and inaccurate. Interview with the Director of Care, nursing staff, and the Food Service Supervisor confirmed that the nutrition and hydration intake records were incomplete.
2.The Home's policy and procedure for nutrition and hydration revised April 2013 –TAB 07-24 stated the extra fluids consumed by the resident will be documented by the RPN/RN at medication pass on the Daily Additional Fluids Chart. Nutrition and Hydration Flow Sheets will be tallied by the night PCA team which will include the Daily Additional Fluids Charts. The Daily Additional Fluid Charts were reviewed on 2 home areas for June 2013 identified the additional fluid charts for multiple residents in each home area have inconsistent documentation for extra fluids intake. The extra fluids intake of resident was not recorded on June 6, 2013, June 16, 2013 and June 24, 2013. Several residents had no fluids intake recorded on the nutrition and hydration flow sheets. The Registered Practical Nurse stated for totaling the resident intake for 24 hour period, extra fluids consumed by the resident should be documented on the Daily Additional Fluids Chart prior to transcribing on the nutrition and hydration intake flow sheets.
3. The home's policy and procedure for "Hydration Therapy" last reviewed June 2013 stated "monitor insertion site and infusion rate every 4 hours and as required. Record input on the " Hydration Form." The Registered Practical Nurse and the Food Service Supervisor confirmed the total amount of intravenous fluid infused over 24 hours should be recorded on the nutrition and hydration flow sheets prior to totaling the resident fluid input for the 24 hour period. The policy and procedure was not complied for resident #0004. The plan of care for the resident stated resident received treatment. Resident's documentation of fluid on the treatment form was reviewed for May, 2013 and June 2013 and fluid infused was not consistently recorded. The fluid intake recorded on the nutrition and hydration flow sheets and on the treatment form did not consistently match in total amount of fluids consumed for each 24 hour period. The resident's plan of care stated the resident was to receive 1450ml fluids per day. The documentation on the nutrition and hydration intake flow sheets indicated the resident did not receive the required amounts of fluids for each of 14 days in June 2013.
4. The policy and procedure for treatment was not complied for Resident #0005. The resident's plan of care stated resident received treatment as required. The

resident's documentation of fluid intake was reviewed for June 2013 and fluid intake was not recorded. The documentation on the treatment Form, Daily Additional Fluids Chart and the Nutrition and Hydration flow sheets did not match in total amounts of fluids iintake over 24 hour period. The documentation on the nutrition and hydration flow sheets indicated the resident did not receive the required volume of fluids for each 15 consecutive days.
5. The Policy and Procedure "Hydration"Tab 07-24 No.2 indicated the RPN will assess signs and symptoms of dehydration. If the resident exhibits signs and symptoms of dehydration, ensure the request for Nutrition Consultation has been initiated. If the resident is consuming less than 1,000 ml /day for three consecutive days, notify the physician." Resident #0006 plan of care identified resident at risk for dehydration due to insufficient fluid intake. A review of the fluid monitoring Nutrition and Hydration flow sheets indicated that the resident consumed less than 1,000ml fluids/day, for 3 consecutive days. The Registered Practical Nurse and the RAI Coordinator confirmed that the referral for nutrition consultation was not initiated and the physician was not notified. Registered Dietitian interview further confirmed that the referral for nutrition consultation was not made.

A previous order related to the same noncompliance was issued to the licensee on October 31, 2013, and April 26, 2013. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures the care set out in the plan of care is provided to residents, including residents #0003, 0004, 0005, 0007 as specified in the plan related to fluid requirements and special nutritional requirements. The plan is to be submitted by August 15, 2013 to Long-Term Care Homes Inspector Asha Sehgal. Asha.Sehgal@ontario.ca

Grounds / Motifs :

1. Resident # 0005 was ordered on June 2013 by the attending physician to receive treatment as necessary to supplement fluids if the resident did not consume 1400cc per 24 hours. The Registered Practical Nurse (RPN) confirmed that this order would be implemented if the resident had not consumed 1400 cc of fluid for three consecutive days. A review of the fluid monitoring indicated that the resident did not consume 1400ml fluids per 24 hour period for 8 consecutive days and interventions were not initiated as directed by the attending physician. (159)

2. Resident #0004 did not receive care as specified in the plan of care related to fluid requirement. The plan of care stated fluid plan as 250ml water at all meal and 175 ml hot beverage. On June 26, 2013 at 1240 hours the resident received meal tray, the fluids served were thickened milk 125 ml, thickened water 125ml and 125 thickened apple juice, hot beverage was not offered. The private care aide assisting resident with eating confirmed the resident was to receive hot beverage and 250ml honey thickened water. The resident's progress notes and the plan of care identified resident received treatment due to insufficient fluid intake. Resident did not receive the fluids and the amounts as specified in the plan of care. (159)

3. Resident #0007 plan of care dated June 2013 stated resident be provided double portion at each meal. The resident was observed by the inspector in the dining room on June 26, 2013. Resident received full pureed meal with regular portions of entrée, bread and salad. Nutritional Risk Screen Quarterly assessment completed April 2013 identified the resident has a history of gradual weight loss, insufficient food and fluid intake. The resident did not receive double portions of entree, vegetable and dessert. (159)

4. The plan of care for Resident # 0003 indicated the resident be provided double portion of protein at lunch and dinner, however, resident was served regular portion of entrée at lunch on. A staff person , Private Care Aide (PCA) was observed assisting the resident with eating. The lunch meal served to the resident consisted of cream of soup, pureed chicken, pureed bread, pureed salad. Resident was served regular portion of entrée (pureed chicken). The staff person (PCA) interview stated that the dietary staff served regular portion of entrée. The plan of care dated April 2013 identified the Registered Dietitian (Hospital) had recommended resident to receive two protein at breakfast and double protein portion at lunch and dinner. Minimum Data Set (MDS) full assessment completed April 2013 the resident was identified as a high risk for meeting the nutritional requirement due to medical diagnosis. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that residents are reassessed and their plans of care reviewed and revised (b) the plans of care are revised when care set out has not been effective and different approaches and strategies are considered in the revision of the plan of care. The plan is to be submitted by August 30, 2013 to Long -Term Care Homes Inspector Asha.Sehgal@ontario.ca

Grounds / Motifs :

1. The plan of care for Resident #0008 was not revised and different approaches were not considered when care set out in the plan of care not effective in relation to insufficient fluid intake. A review of resident's Nutrition and Hydration record for May 2013 and June 2013 indicated most days resident consumed less than 1,000ml fluids a day. . The plan of care dated June , 2013 identified estimated fluid requirement 2250ml fluid/day.
The progress notes dated June 2013 identified that the registered dietitian received a referral regarding resident's insufficient fluid intake. The registered dietitian's documented notes stated "Based on the current body weight fluid requirement is 2200 ml /day. Reviewed hydration flow sheet (June/13) fluid intake is variable from 800-1400, 1700ml/day). Resident is meeting fluid needs. No s/s of dehydration noted. No change." The registered dietitian had identified resident's inconsistent fluid consumption and resident not meeting the assessed hydration needs, however, the interventions were not evaluated and different

approaches were not taken in the revision of the plan to address resident's insufficient fluid intake and dehydration risk. (159)

2. Resident #0006 plan of care identified resident at risk for dehydration due to insufficient fluid intake. A review of the fluid monitoring Nutrition and Hydration flow sheets indicated that the resident consumed less than 1,000ml fluids/day, for 3 consecutive days. The Registered Practical Nurse and the RAI Coordinator confirmed that the referral for nutrition consultation was not initiated and the physician was not notified. Registered dietitian interview further confirmed that the referral for nutrition consultation was not made. (159)

3. The plan of care for Resident # 0005 was not revised and different approaches were not considered when care set out in the plan not effective in relation to risk for dehydration. The plan of care included a requirement for the resident's daily fluid intake 1400 mls/day, however, food and fluid intake documentation reviewed for 3 month period (March, April, May, 2013), reflected the resident was consuming less than 1,000ml fluid/day. The registered dietitian completed RAP assessment June 2013, however, did not include an evaluation of resident's fluid consumption and effectiveness of intervention in relation to insufficient fluid intake. The plan of care was not revised and did not include strategies/intervention to mitigate dehydration risk. Review of the progress notes, interview with the dietitian confirmed that nutrition and hydration assessment was not completed. The plan of care identified resident received treatment due to insufficient fluid consumption.

The plan of care for Resident #0005 was not revised and different approaches were not considered when care set out in the plan not effective in relation to unplanned significant gradual weight loss (Low Body Mass Index). May , 2013 the progress notes indicated the registered dietitian received a referral regarding weight loss of 3.3kg over one month period (April to May 2013). The documented notes stated " Current weight was below the Goal Weight Range (GWR)." The dietitian reviewed the nutrition hydration flow sheets for April 2013 and clarified the resident diet order, however, there was not re-assessment of the resident in relation to weight loss and the evaluation of interventions that had been implemented in May 2011. The registered dietitian had stated the plan was to continue with the current nutrition plan. The resident was noted to be eating poorly and often refusing fluids (as per progress notes and nutrition and hydration flow sheets and nursing staff interview). The interventions were not

evaluated for effectiveness in relation to the goal weight for the prevention of further weight loss. (159)

4. The plan of care for Resident #0004 related to risk for dehydration was not reviewed and revised to ensure that the different approaches were included in the revision of the plan when resident was reassessed on May 2013. The progress notes and interview with the dietitian and the nursing staff confirmed that the resident was at high risk for dehydration due to insufficient fluid intake. The registered dietitian's notes dated May, 2013 stated that a referral was made to assess resident's inconsistent fluid intake. The dietitian stated that the resident's fluid intake was 1,000-1,100 ml/day and was below 1200cc/day and not meeting the assessed fluid requirement 1450ml/day. The plan was to continue with the current hydration plan in place and no change. The resident was identified be on prolonged use of treatment due insufficient fluid intake. The plan of care for the resident related to dehydration and fluid maintenance was not revised and did not include intervention and strategies related to minimizing risk for dehydration. Nutrition and hydration interventions were not evaluated for effectiveness in relation to the assessed fluid requirements. (159)

5. Resident #0002 identified as experiencing a gradual unplanned weight loss was not reassessed and the plan of care not reviewed and revised to address the weight change. Noted at the January, 2013 quarterly review the resident had a goal to maintain weight within goal weight range (GWR). The progress dated May, 2013 documented by the registered dietitian identified the current weight was below the goal weight. The resident had a 7% weight loss April 2013 to June 2013, however, action was not taken and out comes were not evaluated in relation to the goal for weight maintenance within a goal weight range. The interventions were not reassessed and strategies were not planned to address the weight loss. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
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

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

and the Director

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 26th day of July, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ASHA SEHGAL

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