Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
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Bureau régional de services de Centre-Est
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 16, 2021	2021_595110_0004	002993-21, 002994-21, 002995-21, 002996-21, 002997-21	Follow up

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North Whitby ON L1R 3A5

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

DIANE BROWN (110), DENISE BROWN (626)

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): March 18, 19, 22-26, 2021. April 1 and 7, 2021.

Follow-up inspections to previously issued Compliance Orders (CO) from Inspection #2020_715672_0004 were completed as follows:
-Log #002993-21 related to CO #001 and the unsafe positioning of residents who require feeding assistance.
-Log #002994-21 related to CO #002 and failing to ensure a meal is not served to a resident until someone is available to provide the required assistance.
-Log #002995-21 related to CO #003 failing to ensure the proper storage of drugs and medications.
-Log #002996-21 related to CO #004 failing to ensure medications are only administered to residents in the home by the professionals outlined in the legislation.
-Log #002997-21 related to CO #005 failing to ensure all staff participate in the implementation of the Infection Prevention and Control program.

During the course of the inspection, the inspector(s) spoke with Assistant General Manager, Director of Nursing Care, Registered Dietitian, Kinesiologist, Registered Nurses and Registered Practical Nurses, Registered Nurse Student, Personal Support Workers, Dietary Aides, Housekeepers, essential visitors.

During the course of the inspection the Inspectors toured resident neighbourhoods, conducted observations, reviewed clinical records and relevant policies.

The following Inspection Protocols were used during this inspection:
Dining Observation
Infection Prevention and Control
Medication
Nutrition and Hydration

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

3 WN(s)
2 VPC(s)
1 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
O.Reg 79/10 s. 129. (1)	CO #003	2021_715672_0004	110
O.Reg 79/10 s. 131. (3)	CO #004	2021_715672_0004	626
O.Reg 79/10 s. 229. (4)	CO #005	2021_715672_0004	110
O.Reg 79/10 s. 73. (2)	CO #002	2021_715672_0004	110

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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

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:
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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure the resident was provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A mealtime observation was conducted and Resident #001 was observed for the level of encouragement and eating oversight set out in their plan of care. From 1216hrs until 1234hrs resident #001 was observed sitting with soup and beverages with no eating attempts or staff encouragement or assistance. At 1228hr the resident appeared asleep and at 1234hr while still unapproached by staff, the Inspector brought the resident observations to the attention of the RN. The RN confirmed the resident's need for supervision and encouragement. The resident's weight record revealed a weight loss over the past months.

Sources: observations, care plan, clinical record and interview with RN #108. [s. 73. (1) 9.]

2. The licensee has failed to ensure that proper techniques are used to assist the resident with eating, including safe positioning of residents who require assistance.

A mealtime observation identified resident #002 being assisted by RPN #100 who was standing while assisting the resident with their meal. The resident's head was in a flexed position, looking up towards the standing staff. The resident was not in a safe position while being provided feeding assistance. The Inspector approached the RPN, who repositioned the resident and acknowledged they should not be standing to assist the resident with their meal but rather sitting down.

Sources: Observations, interview with RPN #100, RD, plan of care documentation, and Schlegel Villages Supportive Dining Training program. [s. 73. (1) 10.]

3. A mealtime observation was conducted and Resident #005 was observed being assisted with eating while their head was in a hyperflexed position; extended back with the resident's eye directed towards the ceiling. The Inspector immediately requested the Assistant General Manager presence, who intervened and acknowledged the unsafe feeding position of the resident. The resident's plan of care directed staff to ensure the safe positioning of the resident at meals.

Sources: Observations, interviews with RPN #107, RD #101 Assistant General Manager, resident health record. [s. 73. (1) 10.]

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 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. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

LTCHA s. 11. (1) requires the home to have an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

The homes' policy entitled 'Dietary Need Texture Modification Protocol' Tab 07-51 directs a comprehensive assessment to be carried out before a physician's or dietitian's diet texture order is requested and that the RD will collaborate, review documentation and assess the resident and document the results and decision of the assessment.

A record review identified a nursing referral sent to the RD sharing that resident #002 was having difficulty with the current diet texture; to reassess the resident and that a three day trial of a lower textured diet was to be initiated. Three days later the RD changed the resident's diet order to the lowered texture stating the resident was trialed on this texture which was tolerated well and the resident showed no concerns.

An interview with RPN #100 stated that nursing staff would make the suggestion for a diet texture change but the RD is one who assesses the appropriateness. An interview with the RD acknowledged the need for a further assessment prior to downgrading resident #002's diet texture.

Sources: observations, interviews with RPN #100 and the registered dietitian (RD), resident #002's clinical record. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

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:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration.

A mealtime observation identified the lack of eating assistance provided to resident #001 and their poor fluid intake. Documentation by the RD identified resident #001 at moderate hydration risk related to their fluid intake being less than 75% of their daily fluid. The resident's plan of care failed to include the resident's poor fluid intake and lack of mealtime assistance as risks related to their hydration.

Sources: observations, record review of plan of care, RD documentation, Dietary Intake-Follow-up Look back Report in PCC and the RD interview. [s. 26. (3) 14.]

2. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home assess the resident’s hydration status, and any risks related to hydration.

A mealtime observation was completed on March 22, 2021 and identified resident #001 not receiving the encouragement and cueing to eat and drink as required by their plan of care.

Documentation by the RD identified resident #001's weight loss and the resident's average daily fluid intake over an identified period. The RD's documentation also included the resident's estimated daily hydration requirement. The resident's intake was not meeting their hydration requirement and the RD placed them at moderate hydration risk. A further review of the documentation failed to include an assessment of the risk and a subsequent hydration plan as part of a RD assessment. The Inspector completed a record review revealing that a subsequent 12 day period resident #001 consumed a daily average of fluid less than their estimation suggesting the resident continued to remain at moderate hydration risk. The lack of sufficient encouragement and cueing at meals was not assessed as a risk factor to the resident's poor fluid intake and moderate hydration status.

Sources: observations, record review of plan of care, RD documentation, Dietary Intake-Follow-up Look back Report in PCC and the RD interview. [s. 26. (4) (a),s. 26. (4) (b)]

3. Resident #006 was identified by a PSW to be a a poor drinker. The RD documented the resident’s average fluid intake per day. The RD's documentation also included the resident’s estimated fluid needs which placed the resident at moderate hydration risk. An assessment was not completed of the resident's poor fluid intake and the risk factors to their hydration.

Sources: staff interview, PSW #109, RD and record review. [s. 26. (4) (a),s. 26. (4) (b)]

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 based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration, to be implemented voluntarily.

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

Issued on this 23rd day of April, 2021

[redacted]

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

Original report signed by the inspector.

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), DENISE BROWN (626)
Inspection No. / No de l'inspection :	2021_595110_0004
Log No. / No de registre :	002993-21, 002994-21, 002995-21, 002996-21, 002997-21
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 16, 2021
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Taunton Mills 3800 Brock Street North, Whitby, ON, L1R-3A5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Daniel Kennedy

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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 Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_715672_0004, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents’ Council.
3. Meal service in a congregate dining setting unless a resident’s assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents’ diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident’s assessed needs.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be complaint with r. 73. (1) 10 of O. Reg. 79/10.

Specifically, the licensee must:
1. Ensure all residents are safely positioned while being assisted with eating, whether being assisted in bed, the dining room or lounge areas at meals and snacks.
2. Conduct meal/snack time audits throughout the home until compliance is achieved to the safe positioning of resident's while being assisted. If unsafe positioning is noted, redirect immediately and provide reeducation. Keep a documented record of the audits completed.
3. If there are any concerns with resident positioning for dining a referral can be made to an OT, SLP or other allied heath professional as appropriate in keeping with the home's policy Safe Positioning of Residents When Dining Tab 06-03.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques are used to assist the resident with eating, including safe positioning of residents who require assistance.

The home was issued a compliance order on June 2, 2020 within report #2021_715672_0004, related to O. Reg. 79/10, s.73.(1) 10, with a compliance due date of February 17, 2021. A follow-up inspection was conducted and identified continued non-compliance to providing the safe positioning of residents while being assisted with eating.

The licensee has failed to ensure that proper techniques are used to assist the resident with eating, including safe positioning of residents who require assistance.

A mealtime observation identified resident #002 being assisted by RPN #100 who was standing while assisting the resident with their meal. The resident's head was in a flexed position, looking up towards the standing staff. The resident was not in a safe position while being provided feeding assistance. The Inspector approached the RPN, who repositioned the resident and acknowledged they should not be standing to assist the resident with their meal but rather sitting down.

Sources: Observations, interview with RPN #100, RD, plan of care documentation, and Schlegel Villages Supportive Dining Training program. [s. 73. (1) 10.]
(110)

2. A mealtime observation was conducted and Resident #005 was observed being assisted with eating while their head was in a hyperflexed position; extended back with the resident's eye directed towards the ceiling. The Inspector immediately requested the Assistant General Manager presence, who intervened and acknowledged the unsafe feeding position of the resident. The resident's plan of care directed staff to ensure the safe positioning of the resident at meals.

Sources: Observations, interviews with RPN #107, RD #101 Assistant General Manager, resident health record. [s. 73. (1) 10.]

A re-issued order was served taking into account the following factors:.

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position.
Scope: The scope of this non-compliance was patterned as two residents were observed being assisted with their meal while in an unsafe position.
Compliance History: One related non compliance (order) was issued in the last 36 months.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of April, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DIANE BROWN

Service Area Office / Bureau régional de services : Central East Service Area Office