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

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

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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 9, 2018	2018_594624_0010	009734-18	Resident Quality Inspection

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street AURORA ON L4G 3G8

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

BAIYE OROCK (624), DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 31, June 1, 4, 5, 6, 7, 11, 12, 13, 14, 15, 18, 19, and 20, 2018. A follow up telephone interview was also conducted on June 25, 2018.

The following Complaints, Critical Incident Report (CIR), and Follow Up intakes were inspected during this inspection:
Complaints:
007088-18 - Related to nutrition care and staffing concerns,

010516-18 - Related to allegations of neglect of a resident, and
013374-18 - Related to whistleblowing protections
Critical Incident Report:
Log #002104-18 - Related to disease outbreaks.
Follow Up:
Log #026759-17 - Follow up of three inspector orders related to nutrition and hydration, plan of care, and safe and secure home, from report #2017_595604_0015, issued to the home on November 23, 2017.

During the course of the inspection, the inspector(s) spoke with the Director of Operations (for OMNI), Administrator, Director of Care (DOC), Food Service Manager (FSM), Environmental Service Manager (ESM) Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Dietitian (RD), Physiotherapist, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Housekeepers, Cooks, a Hairdresser, president of Residents' Council, family members and residents.

A tour of the home was completed and observations were made of resident to resident interactions, staff to resident interactions during care provision, and medication administration. A review was also completed of residents' health records, medication incidents reports, the licensee's internal investigation records, disease outbreak line lists, evaluation records of the home’s infection prevention and control (IPAC) program, bedrail entrapment/assessment records, Residents' Council meeting minutes, Professional Advisory Committee (PAC) meeting minutes, maintenance and housekeeping audits of windows, as well as relevant policies and procedures related to nutrition and hydration, IPAC practices, zero tolerance of abuse and neglect, whistleblowing protection and the management of complaints.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **12 WN(s)**
- **9 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.O. 2007, c.8 s. 5.	CO #002	2017_595604_0015	624
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #003	2017_595604_0015	624

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month; a change of 7.5 per cent of body weight, or more, over three months and a change of 10 per cent of body weight, or more, over 6 months are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Resident #013 was triggered during stage 1 of the Resident Quality Inspection (RQI) for weight loss.

Resident #013 was not interviewable.

A review of the weight summary report in Mede-care identified that resident #013's weight decreased by 13.8 % over an identified one month period, and continued decreasing over the next three month period. By the sixth consecutive month, resident #013 was noted to have lost 17.9% of their body weight.
A record review of progress notes and written plan of care over the six month period identified above, failed to identify a nursing assessment or documentation around resident #013's significant weight loss.

Interview with RN #108, revealed they thought resident #013 had lost weight and revealed the way they knew was when the resident received a specified intervention. The RN further confirmed that they were full time and nursing staff have never assessed changes in resident's weight as part of an interdisciplinary approach. An interview with

PSW #115, the PSW stated they were not aware if resident #013 had lost weight.

An observation of resident #013 at a specified meal service on an identified date, revealed the resident declined feeding assistance, held a mug of coffee and seldom drank. The resident was served a specified meal texture and the meal was not consumed. An alternative approach, according to the resident's written plan of care, was not provided.

2. Resident #002 also triggered during stage 1 of the RQI for weight loss. The resident was not interviewable.

A review of the weight and height history report in Mede-care identified that resident #002's weight decreased by 8.5 percent over an identified one month period, and decreased by 8.8 percent over an identified three month period. Between the end of the identified three month period and the fourth month, resident #002's weight decreased by 5.9percent.
A record review of progress notes and the resident's written plan of care over the identified four month period failed to identify a nursing assessment or documentation of resident's significant weight loss.

In an interview with PSW #101, the PSW was unaware resident #002 had lost weight.

Resident #002 was observed at a specified meal service on an identified date and the observation indicated that resident needed total assistance with meals. Resident #002's written plan of care required the resident to be served a specified intervention, which was not provided during the lunch meal service. This intervention, which was prescribed by the Registered Dietitian on a specified date, was intended to provide additional nutrition to prevent weight loss.

In an interview with a full time dietary aide (DA) #118, the DA confirmed the resident had not been receiving the intervention ordered by the Dietitian. In an interview with RPN #111, the RPN revealed that registered nursing staff do not assess resident's changes in weight.

3. This inspection was initiated related to weight loss triggered during stage 1 of the RQI.

A review of the weight and height history report in Mede-care identified resident #026's weight decreased by 7.8 percent over the first three months of admission into the home.

A record review of the resident's health record failed to identify a nursing assessment of the weight loss of three months after admission into the home.

Interviews with PSW #101 and #110 on an identified date, revealed they were unaware resident #026 had lost weight but acknowledged the resident only accepts a specified intervention in the dining room at a specified meal and will stay in their room for the other two meals of the day, for which tray service was offered.

Resident #026 declined an interview with inspector #110.

Interview with RPN #111 revealed that they were unsure if the resident had lost weight but shared that on an identified date, the resident took the specified intervention at the specified meal above, which was their usual, and refused the other two meals of the day. RPN #111 also indicated in the interview that resident #026 was also refusing another implemented intervention to promote weight gain.

RPN #111 and RN #108 stated that registered staff do not assess residents' with significant changes in weight as part of an interdisciplinary approach.
Record review of the home's policy, Weight Monitoring, # NC-19, effective date January 2014, directed nursing staff to enter weights into each resident's clinical record through Mede-care.

An interview with the RD revealed that nursing staff do not assess changes in residents' weight and that there was no interdisciplinary approach to assessing weight changes in the home with actions taken and outcomes evaluated. An interview with the DOC confirmed that nursing staff were part of the interdisciplinary team and circle of care in the home. The DOC revealed they were unaware that significant weight changes were to be assessed by nursing and further stated that they were not directed to do so by the home's policy.

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. 71. Menu planning

Specifically failed to comply with the following:

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 :

The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.

A follow-up to order #001 from inspection 2017_595604_0015 was completed.

The home was ordered to complete the following by a specified date.
Within one week of receipt of this order the licensee shall prepare, submit and implement a plan to ensure that:

1) All resident's in the home who have been identified to be on tray service will be offered and informed of the two choices of meals available to them.

2) All residents in the home who complete a weekly regular menu at a glance for each week and month must receive their choice of meals as indicated and chosen by the residents in the weekly regular menu at a glance.

3) Develop and implement a process to ensure all residents receive their choice of meals as predetermined on the weekly regular menu at a glance.

The home had complied with requirement #1 and #3 of the order but failed to comply with requirement #2 of the order.

On an identified date, resident #006 was identified to have a "week 2 regular menu at a glance" posted on the steam table in the kitchen. The menu identified a specified entree for a specified meal service on the identified day in question and for another specified meal service, on another specified day in the weekend.

An interview with cook #114, the cook confirmed the individualized menu for resident #006 and explained the specified entree was a purchased specified entree. The inspector requested to see the specified entrée for the meal in question and cook #114 identified, after reviewing the contents of the freezer, that the specified entree was not

available. Cook #114, stated when asked, that there would not be another food order delivery before the weekend so the specified entree for the weekend meal would also not be available to be offered.

The Food Service Manager was away on vacation and could not be interviewed.

The Administrator confirmed that the planned menu items, according to resident #006's "week 2 regular menu at a glance" menu, were not available to be offered. The Administrator discussed menu alternatives with cook #114 for both meals in question.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1.The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Minimizing of Restraining was triggered for resident #003 during stage 1 of the RQI. On an identified day, Inspector #110 observed resident #003 to be in bed with a specified intervention applied to the bed.

A review of the licensee's Assessment form completed on an identified date for the said intervention for resident #003 indicated that at the resident's request, the said intervention were put in place to promote the resident`s independence. A review of the current written plan of care for resident #003 did not have any focus, goals or interventions related to the use of the identified interventions applied to the bed.

On several observations of the resident's bed made over a two day period by Inspector #624, resident #003's bed was observed to have the said intervention applied in a specified manner.

In separate interviews on an identified date with PSW #109 and RN #108, both indicated that resident #003 uses the said intervention for assistance. Both indicated that the use of the said intervention was not currently found in the resident`s written plan of care and that the expectation in the home is that when the said intervention is in use by any resident, they should be included in the written plan of care for that resident.

In an interview with the Director of Care (DOC), the DOC confirmed that the current written plan of care of resident #003 did not have any focus, goals or interventions related to the use of the interventions applied to the resident's bed. The DOC indicated that the written plan of care of resident #003 is expected to have the said intervention as per the licensee`s expectation for any resident using the intervention in question.

The licensee failed to ensure that the written plan of care for resident #003 sets out the planned care for the resident related to the use of a specified intervention applied to the resident's bed.

2. The licensee failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the residents.

Resident #013 was triggered during stage 1 of the RQI related to weight loss.

Resident #013's written plan of care identified resident at high nutritional risk and when resident was not eating, staff were to provide a specified mixture of food items and offer the mixture to the resident in a specified state.

The dietary sheets in the food service department directed staff that if resident was not

eating to offer the specified mixture in a specified way. A record review of special notes on the dining roster, whereby the staff mark residents' meal selection, directed staff to provide the specified mixture in another specified way.

An interview with staff #117 both cook and dietary aide revealed that they prepared the specified mixture in yet another identified manner. The interviewed staff indicated that there was no clear direction on what should be included in the specified mixture when preparing the food to achieve the specified state.

Interview with dietary aide #116 revealed that directions on what to provide was through word of mouth. They identified that dietary staff seem to prepare the specified mixture in a specified manner. Staff #116 identified that staff followed a specified way of preparing the specified meal during breakfast but that there were no written directions on how to prepare the specified meal.

Interview with cook #114, the cook stated they were directed to prepare the specified meal a particular way during dinner. Staff #114 also revealed that sometimes the specified meal is done another way. Staff #114 also stated that dietary aides sometimes use yet another way to make the specified meal.

An Interview with the Food Service Manager revealed that there was no clear direction on how and what should be included in the specified meal for resident #013.

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

Resident #002 was triggered during stage 1 of the RQI related to weight loss.

A review of the weight and height history report in Mede-care identified that resident #002's weight decreased by 8.5 percent over an identified one month period, and decreased by 8.8 percent over an identified three month period. The Registered Dietitian (RD) assessed the resident on an identified date and ordered a specified intervention to be administered at specified meal services, in addition to other interventions.

An interview with the RD confirmed that the ordered intervention provided an extra nutritional requirements and was intended to prevent further weight loss.
An observation of a specified meal service on a specified day identified dietary aide (DA)

#118 serve resident a similar intervention to that ordered by the RD. Resident consumed 100% of the provided intervention. In a follow-up interview with DA #118, it was revealed they were unaware the resident's plan of care was for another intervention and not the one they had just provided to the resident. The DA #118 confirmed that the resident had not received the intervention as specified in the resident's plan of care.

An interview with the Food Service Manager confirmed that a label had not been prepared for the special intervention and that staff would not have had knowledge to prepare it.

An interview with the RD revealed frustration that the dietary intervention had not been provided as required.

The FSM confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan.

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
1. there is a written plan of care for each resident that sets out, the planned care for the resident,
2. there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and
3.the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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 :

The Licensee has failed to comply with its Weight Monitoring, policy # NC-19.

According to Ontario Regulation (O. Reg.) 79/10, s. 8 (1) b, Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

O. Reg. 79/10, section 68 (2) a, requires the licensee to ensure that the nutritional care and hydration programs include, 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. 69 requires the licensee to ensure that residents with significant weight changes, as defined in the regulations, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Residents #013, #002 and #026 were identified with significant weight losses.

Record review of the licensee's policy entitled Weight Monitoring, # NC-19, Effective date January 2014, identified the role of the registered staff as follows:

1. The designated registered staff shall enter weights into each resident's clinical record through Mede-care.

The reviewed Weight Monitoring policy failed to identify the role of the registered staff in assessing significant weight changes as part of an interdisciplinary approach. The policy, under point #1, only directed registered staff to enter weights into each resident's clinical record through Mede-care.

Separate interviews with RN #108, RPN #111 and the RD revealed that nursing staff do not assess residents with changes in weight. Record reviews further confirmed the lack of a nursing assessment of weight changes.

An interview with the DOC confirmed an unawareness of the requirement that nursing staff, who are part of the interdisciplinary team, were to be involved in the assessment of residents with significant weight changes. The DOC identified that they followed the homes' policy.

The licensee's policy on weight monitoring was not in compliance with the requirements under the LTCHA, 2007 and O. Reg. 79/10.

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 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, (b) is complied with., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible to residents.

During the tour of the home on an identified date, Inspector #624 observed the following on the first floor:
At 1000 hours – the small dining room and adjacent dining area, located at the west end of the building, was observed to not have a resident-staff communication and response system.

At 1005 hours – two residents were having their hair dressed in the hairdressing salon and there was no resident-staff communication and response system in the salon.

At 1010 hours – Several residents where involved in an organized activity program in the large dining room which did not have any staff-communication and response system.

On the same identified date of observation, several interviews were conducted with the hair dresser #100 at 1005 hours, PSW #101 in the small dining room at 1249 hours, and Activity Aid #102 in the large dining room at 1250 hours. All three staff confirmed that there were no resident-staff communication system in the hairdressing saloon as well as both dining rooms. All three staff members indicated that the three mentioned areas above are all accessible to residents.

In an interview with the Administrator on the same day, the Administrator indicated as well that all three areas were accessible to residents and did not have a resident-staff communication and response system. The Administrator however indicated that residents are never in those areas without staff present.

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 home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

The licensee has failed to ensure that the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of Residents' Council (RC) meeting minutes for three consecutive months in 2018 revealed recommendations related to requesting new dining room chairs and if the back door of the home could be left unlocked longer in the evening.

A review of the minutes and RC binder failed to identify a written response to these recommendations.

In an interview, the President of Residents' Council stated they do not always receive a written response to recommendations. The President stated they had followed up a few times asking about the RC's recommendation for new chairs.

An interview with the Administrator confirmed they do not provide a written response to recommendations made by RC and were unaware they were required to do so.

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 if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #7: 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 has failed to ensure that the nutrition care and hydration programs include the development and implementation of policies and procedures, in consultation with a Registered Dietitian (RD) who is a member of the staff of the home.

Record review of the home's policy "Weight Monitoring" policy # NC-19, effective date January 2014 was reviewed and found not to be in compliance with the requirements under the LTCHA, 2007.

An interview with the RD was conducted to determine if, as the member of the staff of the home, they had been consulted in the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration including the weight monitoring policy.

The RD revealed that they had not been consulted on the home's nutrition care and dietary services policies.

2. The licensee has failed to ensure that nutrition care and hydration programs include the identification of any risks related to nutrition care and dietary services and hydration.

Resident #013 and #002 were triggered during stage 1 of the RQI for weight loss.

Residents #013 and #002 were assessed by the RD and provided specified interventions to prevent weight loss.

A review of the diet profile sheets in the food service department identified 30 residents requiring a specified nutritional interventions.

An interview with dietary aide (DA) #118 indicated the location of the recipe for the specified intervention but the inspector was unable to locate the recipe in the area identified by DA #118.

In an interview with DA #116, with the Food Service Manager present, the DA stated their approach on how to prepare the specified intervention ordered by the RD. This method of preparation reported by DA #116 resulted in a specified yield of 13.6 servings of 125mls of milk yielding 13.75 gm of skim milk powder per serving.

An interview with the RD identified that the RD's calculations assumed a recipe yielding 30mls of skim milk powder per serving. After inspector shared the actual recipe in use, the RD was concerned that the residents were receiving less than half of the energy and protein they had been assessed to receive in the prescribed intervention.

This identified risk that residents were not receiving the intervention with the nutritive value assessed by the RD was not identified by the Das, Food Service Manager and RD before it was discovered by the Inspector.

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 nutrition and hydration program (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; (b) the identification of any risks related to nutrition care and dietary services and hydration, to be implemented voluntarily.

WN #8: 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 :

The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

Resident #013 triggered during stage 1 of the RQI related to weight loss.

A review of the resident's plan of care stated if the resident was not eating, staff were to prepare food in a specified manner and give to the resident.

During an Interview with cook #114, the inspector asked to clarify when the specified intervention will be used. Cook #114 stated the previous night's meal they had been asked to prepare different food items in a particular manner for the resident. Cook #114 stated they were uncomfortable in doing so.

An interview with the RD confirmed the resident was offered foods in an identified manner. The RD stated that the resident loves a certain food and providing foods in this specified manner was an intervention. The RD was unable to confirm if the resident was hungry and therefore consumed the combination or simply enjoyed it.

The resident was not interviewable.

An interview with the RD and FSM confirmed that the identified food intervention would not allow for the preservation of the taste or appearance of the identified food which the resident liked.

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 food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

The licensee has failed to ensure that no persons mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 5. The protections afforded by section 26 of the LTCHA, 2007.

Whistle-blowing protections according to LTCHA, 2007, c. 8. s 26 (1) states the following:

(1) No person shall retaliate against another person, whether by action or omission, or threaten to do so because, (a) anything has been disclosed to an inspector; (b) anything has been disclosed to the Director including, without limiting the generality of the foregoing, (i) a report has been made under section 24, or the Director has otherwise been advised of anything mentioned in paragraphs 1 to 5 of subsection 24 (1), (ii) the Director has been advised of a breach of a requirement under this Act, or (iii) the Director has been advised of any other matter concerning the care of a resident or the operation of a long-term care home that the person advising believes ought to be reported to the Director; or (c) evidence has been or may be given in a proceeding, including a

proceeding in respect of the enforcement of this Act or the regulations, or in an inquest under the Coroners Act. 2007, c. 8, s. 26 (1).

On a specified date, complaint log #013378-18 was received by the Ministry of Health and Long-Term Care (MOHLTC). The complainant alleged retaliation from management for reports the complainant had made to the MOHLTC about the care of residents and the management of the home. As a result, the licensee policy/training on whistle-blowing protection (WBP) was reviewed.

An interview with the administrator, also the staff educator, revealed that staff are required to complete annual training on whistle-blowing protection. The training required staff to review on-line surge learning slides entitled 'whistleblowing protection'. The slides, according to the Administrator, are consistent with the home's policy - Whistleblowing Protection, #AM-6.2, effective date January 2015.

A review of the home's surge learning slides and policy on whistleblowing protection were completed. The review revealed that the learning material consistent with the home's policy does not include an explanation of the protections afforded under section 26 of the Long-Term Care Homes Act (LTCHA) of 2007. The learning material refers to only OMNI's whistleblowing protection.

An interview with PSW #129, #130 and #133, revealed they were unsure of what was meant by whistle-blowing protection. Staff #101 and the DOC revealed that whistle blowing protection is protection offered by the management of the home.

An interview with the administrator confirmed that whistle blowing protection afforded by section 26 of the LTCHA had not been communicated to staff and that staff have only been advised on WBP offered by OMNI.

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 no persons mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 5. The protections afforded by section 26 of the LTCHA, 2007, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

The licensee failed to ensure the required information is posted in the home for the purposes of subsections (1) and (2) includes an explanation of the protections afforded under section 26 of the LTCHA, 2007, c. 8, s. 79 (3)(p).

On a specified date, complaint log #013378-18 was received by the Ministry of Health and Long-Term Care (MOHLTC). The complainant alleged retaliation from management for reports the complainant had made to the MOHLTC about the care of residents and the management of the home.

On another specified date, the inspector requested a copy of the home's Whistle Blowing Protection policy. The Administrator stated it was posted and retrieved the home's policy from the bulletin board in the entrance area of the home.

A review of the home's Whistleblowing Protection policy #AM-6.2. Effective date January 2015 was completed by the inspector and the policy did not include an explanation of the protections afforded under section 26 of the LTCHA of 2007.

The policy refers to OMNI HealthCare Whistleblowing Protection and not the protections afforded under section 26 of the LTCHA, 2007. The home's policy included the following, which are not a provision under section 26 of the LTCHA, 2007.

An employee that makes a disclosure shall be protected by the provisions under this policy provided they:
-Have made the disclosure in good faith
-Believe what they have disclosed is substantially true;
-Have not acted maliciously;
-Have not knowingly made false allegations;
-Are not seeking personal or financial gain.

An interview with the Administrator, confirmed the posted information is Whistle Blowing Protection provided by OMNI which did not include an explanation of the protections afforded under section 26 of the LTCHA 2007, Whistle Blowing Protection afforded by the Long-Term Care Homes Act, 2007.

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 required information for the purposes of subsections (1) and (2) is posted in the home related to an explanation of the protections afforded under section 26 of the LTCHA, 2007, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Paragraph 3 (Ontario Regulation 79/10, section 101 (1) 3) states: A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

On a specified date, complaint log #013378-18 was received by the Ministry of Health and Long-Term Care (MOHLTC). According to the complaint, the complainant alleged retaliation from management for reports the complainant had earlier made to the MOHLTC about the care of residents and the management of the home. According to the complainant, the allegation of retaliation as well as other concerns related to resident care were forwarded via email to the Director of Operations of the licensee.

During an interview with complainant on a specified date, the complainant indicated that they are yet to receive a response from the licensee related to the concerns raised in the emails.

A review of the email exchange between the complainant and the Director of Operations of the licensee indicated that on a specified date, the complainant had sent an email to the Director of Operations requesting updates to the raised concerns that were made in writing on three to four months earlier.

In an interview with the Director of Operations of the licensee on another specified date, conducted by Inspector #110 and Inspector # 624, the Director of Operations indicated that it is the licensee's expectation that once a concern has been raised by a complainant, the licensee reviews the complaint, responds to the complainant, investigates the complaint and follows up with the complainant with the outcome of their investigation. On whether the complainant in this case had been informed about the outcome of the investigation and/or what the licensee had done to resolve the complaint, the Director of Operations indicated they were not aware if that was done formally.

Records were requested from the Director of Operations related to the investigation into the concerns raised by the complainant as well as the outcome of any such investigation. The records were received on a later date. A review of the received documents did not reveal that the licensee responded to the complainant within 10 business days or anytime thereafter, indicating what the licensee had done to resolve the complaint, or if the licensee believed the complaint to be unfounded and the reasons for that belief.

The licensee failed to respond to the complainant's written complaint concerning the care of residents and the operation of the home.

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

The licensee has failed to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

On a specified date, complaint log #013378-18 was received by the Ministry of Health and Long-Term Care (MOHLTC). The complainant alleged retaliation from management for reports the complainant had earlier made to the MOHLTC about the care of residents and the management of the home. According to the complainant, the allegation of retaliation as well as other concerns related to resident care were forwarded via email to the Director of Operations for the licensee.

In an interview with the complainant on an identified date, conducted by Inspector #110 and Inspector #624, the complainant indicated that even after complaining to the licensee, MOHLTC and the management of the home, the care concerns continue to occur and management continue to make retaliatory remarks directed at the complainant. The complainant also indicated sending emails to the licensee's Director of Operations about these concerns.

A review of email correspondence between the complainant and the licensee's Director of Operations indicated the following:
In an email on an identified date, the complainant alleged identified concerns.
In another email a week later, the complainant alleged the Director of Care, the Administrator and several staff members made intimidating/retaliatory comments directed at the complainant because the complainant had raised concerns with the MOHLTC. In the same email, the complainant also alleged more concerns.

In a telephone interview with the Director of Operations of the licensee on an identified date, conducted by Inspector #110 and Inspector #624, the Director of Operations indicated that any concern received in writing, the complainant's emails included, is considered a written complaint. The Director of Operations also indicated that written complaints received from family and residents are forwarded to the MOHLTC but when written complaints are received from identified persons, they are handled internally as per the licensee's policy. In the same interview, the Director of Operations also indicated that both emails were not forwarded to the MOHLTC.

The licensee therefore failed to immediately forward both written complaints from the complainant, complaints which were about the care of residents and the operation of the home.

Issued on this 27th day of August, 2018

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BAIYE OROCK (624), DIANE BROWN (110)
Inspection No. / No de l'inspection :	2018_594624_0010
Log No. / No de registre :	009734-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 9, 2018
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	The Willows Estate Nursing Home 13837 Yonge Street, AURORA, ON, L4G-3G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Linda Burr

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

Ontario

Ministry of Health and Long-Term Care

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 : 001

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

Pursuant to / Aux termes de :

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

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 69.

Specifically, the licensee shall ensure that within one month of receipt of this order the licensee shall complete the following:

1. The Registered Dietitian (RD) shall identify all residents with significant weight changes or any other weight change that compromises the resident's health status.

2. A meeting shall be arranged with the interdisciplinary team to assess the weight changes with actions taken and outcomes evaluated related to the identified weight changes.

3. All interventions, as assessed by the interdisciplinary team shall be identified on the resident's plan of care.

4. Review and revise the licensee's weight monitoring policy to reflect the requirements of O. Reg 79/10, s. 69, with clear direction to nursing staff on assessing residents with significant weight changes, and with an implementation date of one month upon receipt of this order.

5. Education shall be provided, with documented dates and staff attendance, to all nursing and personal support staff on the home's new weight monitoring policy, with emphasis on the need for an interdisciplinary approach in the assessment of weight changes.

6. A record is required to be kept by the licensee for all actions undertaken in steps 1 - 5 above.

Grounds / Motifs :

1. The licensee has failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month; a change of 7.5 per cent of body weight, or more, over three months and a change of 10 per cent of body weight, or more, over 6 months are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Resident #013 was triggered during stage 1 of the Resident Quality Inspection (RQI) for weight loss.

Resident #013 was not interviewable.

A review of the weight summary report in Mede-care identified that resident #013's weight decreased by 13.8 % over an identified one month period, and continued decreasing over the next three month period. By the sixth consecutive month, resident #013 was noted to have lost 17.9% of their body weight.

A record review of progress notes and written plan of care over the six month period identified above, failed to identify a nursing assessment or documentation around resident #013's significant weight loss.

Interview with RN #108, revealed they thought resident #013 had lost weight and revealed the way they knew was when the resident received a specified intervention. The RN further confirmed that they were full time and nursing staff have never assessed changes in resident's weight as part of an interdisciplinary approach.

An interview with PSW #115, the PSW stated they were not aware if resident #013 had lost weight.

An observation of resident #013 at a specified meal service on an identified date, revealed the resident declined feeding assistance, held a mug of coffee and seldom drank. The resident was served a specified meal texture and the meal was not consumed. An alternative approach, according to the resident's written plan of care, was not provided.
(110)

2. Resident #002 also triggered during stage 1 of the RQI for weight loss. The resident was not interviewable.

A review of the weight and height history report in Mede-care identified that resident #002's weight decreased by 8.5 percent over an identified one month period, and decreased by 8.8 percent over an identified three month period. Between the end of the identified three month period and the fourth month, resident #002's weight decreased by 5.9percent.

A record review of progress notes and the resident's written plan of care over the identified four month period failed to identify a nursing assessment or documentation of resident's significant weight loss.

In an interview with PSW #101, the PSW was unaware resident #002 had lost weight.

Resident #002 was observed at a specified meal service on an identified date and the observation indicated that resident needed total assistance with meals. Resident #002's written plan of care required the resident to be served a specified intervention, which was not provided during the lunch meal service. This intervention, which was prescribed by the Registered Dietitian on a specified date, was intended to provide additional nutrition to prevent weight loss.

In an interview with a full time dietary aide (DA) #118, the DA confirmed the resident had not been receiving the intervention ordered by the Dietitian.

In an interview with RPN #111, the RPN revealed that registered nursing staff do not assess resident's changes in weight.
(110)

3. This inspection was initiated related to weight loss triggered during stage 1 of the RQI.

A review of the weight and height history report in Mede-care identified resident #026's weight decreased by 7.8 percent over the first three months of admission into the home.

A record review of the resident's health record failed to identify a nursing assessment of the weight loss of three months after admission into the home.

Interviews with PSW #101 and #110 on an identified date, revealed they were unaware resident #026 had lost weight but acknowledged the resident only accepts a specified intervention in the dining room at a specified meal and will stay in their room for the other two meals of the day, for which tray service was offered.

Resident #026 declined an interview with inspector #110.

Interview with RPN #111 revealed that they were unsure if the resident had lost weight but shared that on an identified date, the resident took the specified

intervention at the specified meal above, which was their usual, and refused the other two meals of the day. RPN #111 also indicated in the interview that resident #026 was also refusing another implemented intervention to promote weight gain.

RPN #111 and RN #108 stated that registered staff do not assess residents' with significant changes in weight as part of an interdisciplinary approach.

Record review of the home's policy, Weight Monitoring, # NC-19, effective date January 2014, directed nursing staff to enter weights into each resident's clinical record through Mede-care.

An interview with the RD revealed that nursing staff do not assess changes in residents' weight and that there was no interdisciplinary approach to assessing weight changes in the home with actions taken and outcomes evaluated.

An interview with the DOC confirmed that nursing staff were part of the interdisciplinary team and circle of care in the home. The DOC revealed they were unaware that significant weight changes were to be assessed by nursing and further stated that they were not directed to do so by the home's policy.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 3 as it related to all three of the residents reviewed. The home had a level 3 compliance history as they had past non-compliance with this section of the regulation that included:

-Written Notification (WN) and Voluntary Plan of Correction (VPC) issued on November 6, 2015 (2012_168202_0013). (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 07, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_595604_0015, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 71 (4).

Specifically, the licensee shall ensure that within one week of receipt of this order, the licensee shall complete the following:

1. Identify all residents in the home who complete a weekly regular menu at a glance for each week and/or month.

2. Ensure the identified residents in item #1 above must receive their choice of meals as indicated and chosen by the residents in the weekly regular menu at a glance.

3. Keep a record in the home of all activities undertaken under steps 1 and 2 above

Grounds / Motifs :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.

A follow-up to order #001 from inspection 2017_595604_0015 was completed.

The home was ordered to complete the following by a specified date.

Within one week of receipt of this order the licensee shall prepare, submit and implement a plan to ensure that:

1) All resident's in the home who have been identified to be on tray service will be offered and informed of the two choices of meals available to them.

2) All residents in the home who complete a weekly regular menu at a glance for each week and month must receive their choice of meals as indicated and chosen by the residents in the weekly regular menu at a glance.

3) Develop and implement a process to ensure all residents receive their choice of meals as predetermined on the weekly regular menu at a glance.

The home had complied with requirement #1 and #3 of the order but failed to comply with requirement #2 of the order.

On an identified date, resident #006 was identified to have a "week 2 regular menu at a glance" posted on the steam table in the kitchen. The menu identified a specified entree for a specified meal service on the identified day in question and for another specified meal service, on another specified day in the weekend.

An interview with cook #114, the cook confirmed the individualized menu for resident #006 and explained the specified entree was a purchased specified entree. The inspector requested to see the specified entrée for the meal in question and cook #114 identified, after reviewing the contents of the freezer, that the specified entree was not available. Cook #114, stated when asked, that there would not be another food order delivery before the weekend so the specified entree for the weekend meal would also not be available to be offered.

The Food Service Manager was away on vacation and could not be interviewed.

The Administrator confirmed that the planned menu items, according to resident #006's "week 2 regular menu at a glance" menu, were not available to be offered. The Administrator discussed menu alternatives with cook #114 for both meals in question.

The severity of this issue was determined to be a level 2 as there was a potential for actual harm to the resident. The scope of the issue was a level 1 as it was isolated to a single resident. The home had a level 4 compliance history as they had ongoing non-compliance with this section of the regulation that included:
- A Written Notification (WN) issued on November 6, 2015

(2015_168202_0013), and
- A Compliance Order (CO) issued on November 23, 2017 (2017_595604_0015). (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 24, 2018

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 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, 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
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 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 de la Santé et 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

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 9th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Baiye Orock

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