Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Oct 10, 11, 12, 17, 18, 19, 22, 23, 26, 2012 | 2012_191107_0001 | Complaint |

**Licensee/Titulaire de permis**

1245556 ONTARIO INC.
200 Ronson Drive, Suite 305, TORONTO, ON, M9W-5Z9

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

BURTON MANOR
5 Sterritt Drive, BRAMPTON, ON, L6Y-5P3

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

MICHELLE WARRENER (107)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**During the course of the inspection, the inspector(s) spoke with Residents and family members, The Administrator, Director of Care (DOC), Registered Dietitian (RD), Food Services Manager (FSM), Registered Nursing staff, front line nursing and dietary staff**

**During the course of the inspection, the inspector(s) Reviewed the clinical health record of three identified residents, observed the lunch meal service, and reviewed relevant policies, procedures and protocols related to complaint inspection H-001889-12.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Laundry**

**Nutrition and Hydration**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 26. Plan of care**

**Specifically failed to comply with the following subsections:**

**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**
**(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. [O.Reg. 79/10, s. 26(4)(b)] Section 26(4) previously issued as a VPC January 18, 2011.
The Registered Dietitian did not assess resident #01's nutritional status, including any risks related to nutrition care.
a) A dietary referral related to significant weight loss, poor food intake, constipation, and the resident's request for a special item at breakfast was initiated by nursing staff on two days in one month. Progress notes in the resident's clinical health record indicated the resident had a significant change to their bowel pattern noted the same month, as a result of increasing medications for pain, and significant open areas on their skin. The review by the Registered Dietitian, related to the nursing referral, did not include an assessment of the resident in relation to the increased constipation.
b) A re-assessment of the resident's nutritional risk status did not occur when the resident returned from hospital after a significant change in status. The resident had a downgrade in diet to a modified texture, difficulty swallowing, requiring thickened fluids, poor intake of food and fluids, however, the 'Nutrition/Hydration Risk Assessment Tool' was not completed after the significant change in status (as per the home's policy and procedure) and the resident continued to be identified as moderate nutritional risk, despite the increased risks identified.
2. The Registered Dietitian did not assess resident #02's hydration and risks related to hydration when there was a significant change in their fluid intake. The resident had a fluid requirement of 1275ml fluids per day (as per the plan of care), however, they were documented as consuming less than their requirement over a 6 day period (avg 918/day). A referral to the Registered Dietitian was initiated by nursing staff identifying poor hydration and the Dietitian reviewed the resident at the end of the six day period. The resident was at high nutritional risk, however, an assessment of the poor hydration did not occur and action was not taken to address the poor hydration. Changes were made to the plan of care 11 days prior, however, the effectiveness of the changes were not assessed and the additional reduction in hydration during the six day period was not assessed.
3. The Registered Dietitian did not assess resident #03's hydration status, and any risks related to hydration when the resident's fluid intake was less than their target fluid requirement.
a) At a nutritional review by the Dietitian, the resident was noted to be consuming approximately 1125ml/day of fluids. According to the resident's plan of care, their calculated fluid requirement was 1813 ml/day. There was no assessment of the poor hydration and action was not taken to address the noted poor hydration.
b) One week later there was a weight change warning for a significant weight loss over 6 months. The Registered Dietitian stated the resident's intake of food and fluids was adequate. There was no assessment of the resident's fluid intake in relation to the calculated fluid requirement and in relation to the significant weight loss, and action was not taken to address the poor hydration.
c) The resident did not meet their calculated fluid requirement of 1813 ml/day (noted on the resident's plan of care) on any day recorded over a 2 month period, however, an assessment of the poor hydration did not occur.

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following subsections:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,**
**(i) within 24 hours of the resident's admission,**
**(ii) upon any return of the resident from hospital, and**
**(iii) upon any return of the resident from an absence of greater than 24 hours;**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;**
**(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and**
**(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

[O.Reg. 79/10, s. 50(2)(b)(iii)] Previously issued as a VPC January 18, 2011.
1. The licensee did not ensure that resident #03, who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a Registered Dietitian in relation to the skin breakdown.
a) Resident #03 was documented (in the progress notes) as having an open area on the skin (repeat open area). The Registered Dietitian reviewed the resident related to a significant weight loss warning four days after the noted skin issue, however, there was no assessment of the resident in relation to skin integrity. The plan was to continue with the current interventions and that the weight loss was desirable.
b) Four days after the Dietitian review, the resident was noted to have multiple open areas on their skin. The areas were noted to be open for another month. The Registered Dietitian reviewed the resident during that time for another significant weight loss warning, and again there was no assessment in relation to the poor skin integrity. The Dietitian indicated the weight loss was desirable and no changes were made to the plan of care.
2. The licensee did not ensure that resident #01, who had altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had a nutritional assessment in relation to the skin breakdown. Progress notes in the resident's clinical health record reflected the resident had noted open areas on the skin, progressing to stage 3 three months later, however, there was no assessment by the Registered Dietitian during that time. Skin breakdown was not noted by the Registered Dietitian until after the three months and there was no re-assessment of the resident's energy and protein requirements in relation to the skin integrity concerns. The resident continued to have wounds that were increasing in size and significance without assessment and intervention by the Registered Dietitian until two months after the previous review.
3. The licensee did not ensure that resident #02, exhibiting altered skin integrity, including skin breakdown and pressure ulcers, was assessed by a registered dietitian who was a member of the staff of the home. The resident developed an open area on their skin which was not recorded as healed until almost two months later. During this time the Registered Dietitian did not assess the resident and the Dietitian confirmed that a nutritional assessment related to skin did not occur.

***Additional Required Actions:***

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

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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. [O.Reg. 79/10, s. 69.3] Section 69 previously issued as a VPC on January 18, 2011.
The licensee did not ensure that action was taken and outcomes were evaluated after a 14% significant weight loss over 6 months for resident #02. The Registered Dietitian reviewed the resident related to the significant weight loss, however, action was not taken to address the ongoing weight loss and interventions were not evaluated for effectiveness in relation to the ongoing weight loss. The plan was to continue with the same interventions, which were not effective to prevent further weight loss.
2. [O.Reg. 79/10, s. 69.1,3]
The licensee did not ensure that actions were taken and outcomes were evaluated in relation to significant weight loss for resident #03.
a) A significant weight loss warning was triggered for a 10.6% significant weight loss over 6 months. The Registered Dietitian stated that the significant weight loss was desirable and that the resident's intake of both food and fluids was adequate with no dietary concerns at that time. Progress notes and staff interview identified the resident was eating poorly, missing meals, routinely did not attend the breakfast meal, was not meeting their hydration requirements, had significant weight loss, and the family was concerned about the resident's nutritional intake and brought in additional items for them. Action was not taken by the Registered Dietitian to address the significant weight loss and outcomes were not evaluated in relation to nutrition and hydration goals identified on the resident's plan of care.
b) A significant weight loss warning was triggered for a 10.8% weight loss over 6 months. The Registered Dietitian stated this was a desirable weight loss and action was not taken despite documented ongoing poor intake, poor hydration, previous significant weight loss, noted difficulty swallowing medications with a downgrade to crushed medications, and poor skin integrity with open areas on the resident's skin.
c) A significant weight loss warning was triggered the following month for a 16.8% weight loss over one month. A re-weigh was not taken by staff to confirm the accuracy of the weight (as per the Home's policy and procedure), and the significant weight loss was not assessed. The Registered Dietitian used the previous months weight for her assessment and action was not taken despite repeatedly poor intake, poor hydration, and a history of poor skin integrity.
d) Outcomes were not evaluated, action was not taken and nutritional strategies were not revised over an eight month period, despite ongoing weight loss, poor intake, poor hydration, family concern with the resident's nutritional intake, and poor skin integrity.

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

**WN #4: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
Resident #01 had a plan of care that did not set out clear direction for staff who provided care to the resident.
a) The resident's plan of care (both electronic and paper copy) were reviewed on October 10, 2012, and stated different fluid consistencies were required in different sections of the plan of care (identified both honey consistency and nectar consistency thickened fluids).
b) The Nutritional status section of the plan of care indicated the resident was receiving nutritional supplementation, however, the nutritional supplements were discontinued the month prior.
c) The plan of care identified the resident was receiving therapy for hydration, however, this had been discontinued two months prior. Staff confirmed the resident was no longer receiving the hydration therapy.
d) The diabetes section of the plan of care identified the resident had type one diabetes, however, staff confirmed the resident had type 2 diabetes.
e) Staff interview confirmed the plan of care had not been updated and did not provide clear direction to staff providing care to the resident.
2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(2)]
The plan of care for resident #02 was not based on an assessment of their nutritional needs and preferences. The resident had a plan of care for a nutritional supplement to be placed in an item served at breakfast daily. On admission, the resident identified a dislike of the breakfast item. During interview, the Registered Dietitian stated that the item was not one of the resident's favourites but they would eat it and based on their diet consistency it's something the home provided to the resident. If given a choice they would prefer to have a different breakfast item over the item provided. The resident's plan of care was not based on the resident's preferences and items were provided to the resident based on their diet texture and not based on their preferences. Staff interview identified the resident was intermittently consuming the breakfast item dependent on how hungry the resident was. The staff also confirmed the resident was now receiving the item due to a change in diet texture.
3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(11)(b)]
When residents were reassessed and the plan of care reviewed and revised because the care set out in the plan was not effective, the licensee did not ensure that different approaches were considered in the revision of the plan of care.
a) For Resident #01, nutritional supplements were implemented due to poor intake, however, were discontinued due to poor acceptance the next month. The resident was reviewed by the Registered Dietitian noting the interventions had been discontinued, however, different approaches were not considered in the revision of the plan of care. The plan of care did not include any alternative interventions to address the poor skin integrity (stage 3) and significant weight loss.
b)Different approaches were not considered in the revision of resident #03's nutritional plan of care. The resident was re -assessed by the Registered Dietitian four times over a four month period. Strategies on the resident's plan of care had not been revised over an eight month period, despite ongoing poor intake, poor hydration, missing meals, significant weight loss, and poor skin integrity. The Registered Dietitian confirmed that the plan of care was not revised with additional strategies added when the plan was not effective.
4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(5)]
The licensee did not ensure that resident #03 or the resident's substitute decision-maker (SDM) were given an opportunity to participate fully in the development and implementation of the resident's nutritional plan of care.
The Registered Dietitian confirmed that the resident and substitute decision maker (SDM) were not included in the development of the resident's nutritional plan of care in relation to significant weight loss, concerns about nutritional intake, missed meals, and strategies to improve nutritional intake and hydration.
5. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the the plan of care for resident #02 was not provided to the resident as specified in their plan.
a) The resident's plan of care stated they required all fluids to be thickened to honey thick consistency, however, the resident was receiving un-thickened nutritional supplement at the medication pass. The Registered Dietitian confirmed that the nutritional supplement was required to be thickened, however, Registered staff confirmed the supplement was not being thickened.
b) The resident received nectar thickened water at the observed lunch meal October 11, 2012. Staff confirmed that the water (nectar thick) was not thickened to the same consistency as the orange juice provided to the resident (honey consistency).
c) The resident's plan of care stated the resident wore glasses and to ensure the glasses were being worn. The resident did not have their glasses on during the lunch meal service October 11, 2012 or during the day when observed October 11, and 12, 2012.

*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 with s. 6(1)(c), 6(2), 6(5), 6(7), and 6 (11)(b), to be implemented voluntarily.***

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**WN #5: 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 subsections:**

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

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**Findings/Faits saillants :**

1. [O.Reg. 79/10, s. 8(1)(b)]
The licensee did not ensure that the home's policy and procedure related to the Nutritional Priority screen (04-01-02 Nutrition Care Process), and the nutrition protocol for skin care and wound management (04-01-12), were complied with.
a) The Home's policy 04-01-02 stated a nutrition priority screening tool was to be completed at minimum quarterly and whenever there was a significant change in the resident's health status. Resident #01 had a significant change in condition, (hospitalization, downgrade in diet texture, increased swallowing problems requiring thickened fluids, significant weight loss, poor food and fluid intake), however, a nutrition priority screening tool was not completed and the resident remained at moderate nutritional risk on the resident's plan of care and also at subsequent nutritional reviews over a two month span. The last nutritional risk assessment was completed prior to the significant change in status, indicating the resident was at moderate nutritional risk.
b) The Nutrition Protocol for Pressure Ulcer Healing (04-01-12 A) was not followed in the nutritional assessment of resident #01. The resident had ongoing open areas on the skin over a seven month period that had progressively increased in size and severity to stage 3 wounds.
i) The assessments completed by the Registered Dietitian over a six month period did not follow the protocol identified in the home's policy for pressure ulcer healing. The Registered Dietitian used a calculation of 1.0 g protein/kg of body weight and 22 kcal/kg for energy requirement calculations. The home's protocol for stage 1-2 wounds was 1.2-1.5g/kg protein and 30-35kcal/kg energy and 27-35ml/kg fluids, and for stage 3 wounds stated a requirement of a minimum of 1.5g/kg of protein, 40kcal/kg for energy, and 35-40ml/kg of fluids. Rationale was not provided by the Registered Dietitian for the use of a lower requirement for protein and energy that did not follow the home's protocol.
2. [O.Reg. 79/10, s. 8(1)(b)]
The licensee did not ensure that the Home's weight monitoring policy and procedure was complied with by staff.
The "Changes in Residents Weight" policy 05-08 stated that staff were to re-weigh the resident if there was a discrepancy of 2 kg (+/-) from the previous month's recorded weight and that both weights were to be recorded. All weights were to be completed by the 7th of each month.
Resident #03 did not have a documented re-weigh after a significant weight loss of 16.8% in one month.

*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 with ensuring that where the Act or this Regulation requires the licensee 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 is complied with, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following subsections:**

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(a) is a minimum of 21 days in duration;**
**(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;**
**(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;**
**(d) includes alternative beverage choices at meals and snacks;**
**(e) is approved by a registered dietitian who is a member of the staff of the home;**
**(f) is reviewed by the Residents' Council for the home; and**
**(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).**

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

**Findings/Faits saillants :**

1. [O.Reg. 79/10, s. 71(1)(b)]
The home's menu cycle did not include a menu for residents requiring thickened fluids. Direction was not provided to staff serving residents who required thickened fluids at the lunch meal October 11, 2012. Dessert items offered on the planned menu did not reflect choices appropriate for residents requiring thickened fluids (ice cream). An alternative dessert choice was not planned, prepared, and offered to resident #02, who disliked the first menu choice (watermelon). Dietary staff confirmed an alternative dessert choice was not available at the observed lunch meal. Management staff interviewed stated that a variety of suitable items were available to provide as an alternative menu choice, however, direction was not provided to staff serving the meal with a planned alternative dessert choice to ensure the same level of variety was offered to residents requiring thickened fluids as those receiving the regular menu.
2. [O.Reg. 79/10, s. 71(4)]
The planned menu items were not available and offered to the resident at the lunch meal October 11, 2012.
The planned menu stated milk would be offered at meals, however, milk was not offered to resident #03. Documentation in the resident's clinical record identified a preference for milk and water over juice, however, the resident was provided only water and juice. Staff were unable to tell the inspector why the resident was not offered milk at the lunch meal, as per the planned menu. The resident consumed the milk when it was provided (as requested by the inspector). The resident had significant weight loss in October, was at risk for dehydration, and had poor nutritional intake at meals.
3. [O.Reg. 79/10, s. 71(4)]
The planned menu items were not consistently offered to resident #01 at each meal. The family of resident #01 had offered to bring special items for the resident at meals, however, the resident was not consistently being offered additional items from the planned menu offered at the home. During interview, the resident stated they wanted more variety in the items they were eating. The resident had significant weight loss and was receiving only beverages and sometimes dessert offered by 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 with ensuring the home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snacks, and with ensuring that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.***

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 89(1)(a)(ii)]
Not all of resident #01's clothing was labeled. The resident had two items in their closet that were not labeled. The resident's family member confirmed the items were not newly purchased (within the previous 48 hours). Documentation in the resident's clinical health record identified missing clothing items.

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WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)10]
At the lunch meal October 11, 2012 resident #04 was being fed by staff and proper feeding techniques were not used to ensure the resident's safety. Staff was using a large tablespoon filled with food to feed the resident and when questioned by the inspector, the staff was not aware that the technique was a safety risk to the resident. Registered staff interview confirmed that the practice at the home was to use teaspoons to feed residents who required assistance with eating.

*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 with ensuring proper techniques to assist resident with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.***

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**WN #9: 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 subsections:**

**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;**
**(b) the identification of any risks related to nutrition care and dietary services and hydration;**
**(c) the implementation of interventions to mitigate and manage those risks;**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and**
**(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).**

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**Findings/Faits saillants :**

1. [O.Reg. 79/10, s. 68(2)(e)(i)]
Resident #03 did not have their weight measured and recorded for a one month period. Documentation did not include an explanation as to why the resident's weight was not taken/recorded and staff interview was unable to determine why the resident's weight was not recorded for the month. The resident had a significant weight loss documented the month prior.

**Issued on this 8th day of November, 2012**

| **Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs** |
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| H Warnen, HD |