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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 16, 2017	2016_434631_0016	030831-16	Resident Quality Inspection

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

MILLENNIUM TRAIL MANOR
6861 OAKWOOD DRIVE NIAGARA FALLS ON L2E 6S5

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

KERRY ABBOTT (631), ROBIN MACKIE (511), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 25, 26, 27, 28, 31, 2016, and November 1, 2, 3, 4, 8, 21, 2016.

During the course of this inspection, the following inspections were conducted concurrently: Critical Incident (CI) 019480-15, related to Abuse and Neglect, CI 025680-16, related to Falls Prevention, CI 001952-16, related to Falls Prevention, CI 001589-15, related to Falls Prevention, CI 026359-16, related to Falls Prevention, Complaint 018629-15, related to Food Production and Menu Planning, Complaint 004677-16, related to Accommodation Services, Complaint 028659-16, related to Abuse and Neglect, Complaint 027824-16, related to Abuse and Neglect, and Complaint 034061-16 related to Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director(s) of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, registered staff, personal support workers (PSWs), Manager of Housekeeping/Laundry, Manager of Maintenance Services, Food and Nutrition Manager (FNM), Registered Dietitian (RD), dietary staff, housekeeping staff, President of Residents' Council, residents and families. During the course of the inspection, the inspector(s) toured the home, conducted interviews with residents, staff and families, conducted observations and reviewed records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (4)	CO #001	2016_248214_0012	631
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2016_247508_0009	631

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

Specifically failed to comply with the following:

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

On an identified date, Inspector #631 interviewed resident #012. The resident stated that staff routinely provided an identified device for a specific activities of daily living (ADL). The resident stated that no other devices were used for this specific activity. The resident further stated that their preference would be for staff to assist the resident to utilize another device for this specific activity.

A review of the resident's most recent plan of care indicated that the resident was to be provided an identified device for this specific ADL. A review of the coding in the resident's Minimum Data Set (MDS), stated the resident was physically capable to utilize other devices for this specific ADL, including the device(s) preferred by the resident.

An interview with the Physiotherapist (PT) confirmed that according to an assessment conducted, the resident had the physical capacity to utilize other devices for this specific ADL, including the device(s) preferred by the resident. An interview with the Assistant Director of Care (ADOC) confirmed that the resident utilized one device for this specific ADL, not the preferred device of the resident. An interview with Personal Support Worker (PSW) staff #108 and #107 confirmed that the routine for the resident was to assist the resident with only one device for this ADL, which was not the resident's preferred device. Interview with RPN staff #106 also confirmed that the staff utilized the one, less preferred device for the resident for this specific ADL. The resident's care plan was not based on an assessment of the resident or on the resident's preferences. [s. 6. (2)]

2. On a specified date in 2016, resident # 004 was observed with an assistive device in place.

During interview PSW #110 and #131 stated that the device was used to assist the resident. Review of resident's clinical records indicated that the resident was admitted to the home with the device in place. The physician in hospital had ordered the use of the device prior to discharge. Record review identified that following admission to the Long-term Care Home there was no documented assessment for the use of the device, which was confirmed by the DOC and Administrator. [s. 6. (2)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan is no longer necessary.

A report was submitted by the home to the MOHLTC for a fall incident that occurred in 2016. Resident #012 was described to have fallen out of their chair when their wheelchair tipped backwards. The resident was sent to hospital for assessment and returned to the home later that same evening. On a specified date in 2016, the resident received personal care in bed and was provided analgesic, for pain with little effect. The resident was documented to have an injury and pain when touched. The following day the home's physician reviewed a medical report, confirmed an injury and stated the resident should be wearing a device for a specified period of time. Attempts by the home to obtain the device, specific for the resident, were documented as unsuccessful. The ADOC documented in the clinical record, after a discussion with the home's physician, that the resident was sent to the hospital as the home was not able to provide the device and required treatment. The resident returned to the home a few days later, with the

device in place. The home completed the first pain assessment, post fall, and indicated the analgesic was effective for pain. The resident remained in bed with direction to not remove the device. The resident received analgesic as required on a specified date in 2016, three (3) times throughout the day for pain. The following day they received analgesic as required on one occasion for pain with an intervention to follow up for effectiveness. Three days later, the family physician was to follow-up with specialist to determine a safe level of activity related to the injury. The progress notes indicated that the device remained in place. The following day, the resident was documented to have complications due to wearing the device. On another identified date in 2016, the resident complained of discomfort from the device and requested to remove the device. Registered staff #114 advised that the device was to remain in place. On another identified date in 2016, the resident had removed the device. The home's physician was notified that the resident had been consistently removing the device due to discomfort. On another identified date in 2016, an appointment with the specialist indicated the device could be discontinued and the resident could resume their regular activities.

A review of the resident's most recent plan of care indicated:
Pain: Pain related to injury from fall. An intervention was to administer pain medication as per the doctor's orders and note effectiveness. This was revised in the plan of care on an identified date in 2016 and resolved the same day. As indicated above, the progress notes identified the resident had initial pain on an identified date in 2016, nearly one month before the plan of care was updated, and continued to complain of discomfort.

Device: Resident to be assessed for comfort and pain levels routinely when wearing the device and if the resident refused to wear the device, health teaching was to be provided. The plan of care was updated with the intervention of the requirement of the device on an identified date in 2016, nearly two weeks after the resident's device had been applied. The identification of the injury was on an identified date in 2016. This plan of care focus was further resolved and removed from the plan of care, four days later despite the ongoing concerns as identified above.

Interview with both the DOC and the RAI MDS Coordinator confirmed the resident's plan of care was not updated when the resident's care needs changed. [s. 6. (10) (b)]

4. The licensee failed to ensure that when a resident was reassessed and the plan of care was reviewed and revised, because care set out in the plan has not been effective, that different approaches were considered in the revision of the plan of care.

A review of the clinical record, for resident #041, identified that the resident had a history of unsteady gait and balance. According to their plan of care they required extensive assistance by one staff, used their mobility device when in their room and a wheelchair for longer distances. The resident was documented to often reach for items, resulting in falling from their wheelchair, and had been non-compliant with consistent use of their mobility device.

A review of the home's 2016 Risk Management reports, progress notes, plan of care and falls tracking record identified the resident had fourteen (14) falls in the previous eight (8) months.

A review of the resident's written plan of care, that spanned eight (8) months (January - August 2016), had not identified any new interventions when the resident continued to fall. An interview with RPN # 115 confirmed that there had been no new interventions provided in the plan of care when the plan of care had been reviewed and revised through January to August 2016. An interview with RPN #118 confirmed the resident had continued to be a high risk for falls and continued to experience falls during this time and that when the care set out in the plan had not been effective, the licensee had failed to ensure that different approaches had been considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the policy and procedure was complied with.

The following used, personal items were found on the top of the counter tops and on the top of linen cards located on Elgin, Chippawa and Montrose tub rooms: three (3) unlabelled black hair combs and three (3) white hair brushes, one (1) Degree deodorant, one (1) disposable razor and one (1) unlabelled shaving cream. The interviews with staff # 100, #101, #103, #104 and the DOC identified that residents' personal items were to be labeled. The home's admission policy's HCA/PSW Admission Checklist, PCN-A-13-1, contained information about labeling residents' personal items, which included hair brushes and combs and shaving devices. The staff did not insure that the Admission policy and procedures were complied with. [s. 8. (1) (b)]

2. The licensee failed to ensure that where the act of regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, procedure strategy or system, the licensee is required to ensure that it is complied with.

Ontario Regulation 79/10 73.(1) 5. indicates that the home is required to have a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On an identified date in 2106, Inspector #632 observed a Dietary Type Report, which was used as a reference tool by the Dietary staff in the home, contained information that was not current according to the residents' plan of care related to their diet type and food textures. The Dietary Type Report contained incorrect food textures for resident #033 and #034 and contained incorrect diet for resident #035. An interview with PSW staff #129 and #130 identified that they referred to both the Dietary Type Report and to the Kardex for residents' diet types and food texture. On an identified date in 2016, an interview with the Food and Nutrition Manager (FNM) confirmed that dietary staff did not update the Dietary Type Report with the information provided by FNM. The FNM further indicated that the home's process was that the dietary staff were to update the Dietary Type Report when information was provided by the FNM and that the staff had not followed the home's process to ensure that all staff assisting residents were aware of the residents' diets, special need and preferences. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the act of regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, procedure strategy or system, the licensee is required to ensure that it is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

On an identified date in 2016, Inspector #631 observed a one-quarter bed rail device on resident #023's bed.

A review of the resident's record indicated that the home had conducted a Safety Assessment, which evaluated the resident to be at risk of falling out of bed as well as a consent form signed by the resident's Power of Attorney (POA).

On an identified date in 2016, the Administrator confirmed that she was aware of the bed rail. The Administrator stated that the family had requested this rail be placed on the bed on admission. The Administrator confirmed that no alternatives had been offered to the POA. The Administrator stated that she was aware that the bed rail would not pass entrapment as it was not designed or approved by the manufacturer to be placed on the bed. [s. 15. (1)]

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 bed rails are used, the residents are assessed and his or her bed system is evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, to minimize risk to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following interdisciplinary program was developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's, January 2016, Fall Prevention and Management Program was reviewed. The program identified the following components to their Fall Prevention Program: Assessment, Interventions, Evaluation and Education to staff and residents.

The direction under the Education component referred to using alert messaging to identify residents who were at a high risk for falls. An interview with the Director of Care (DOC) confirmed this alert messaging was in the form of a falling leaf that would be placed above the resident's bed light. A review of the clinical record for resident #041 identified they were at a high risk for falls and had experienced fourteen (14) falls during an eight (8) month period in 2016. An observation of resident #041's room had not provided for a falling leaf above the resident's bed light. The DOC confirmed that a falling leaf should have been placed above the resident's bed light as part of the Fall Prevention and Management Program.

The direction under the Evaluation component indicated a resident specific evaluation was to be conducted to determine the success of the falls prevention strategies quarterly, annually and after each fall. The Evaluation component further described that the home would track the number of falls/fractures that have occurred and provide an analysis of these falls monthly. Interview with Registered Practical Nurse (RPN) # 118 and the Director of Care (DOC) confirmed the home had not tracked and analyzed the falls monthly in 2016 for resident #041. The DOC confirmed the home had a Falls Prevention team and had started to meet weekly in the third quarter of 2016 and had confirmed that not all components of the Fall Prevention and Management Program had been implemented in the home in 2016. [s. 48. (1) 1.]

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 an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury be developed and implemented in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, (e) continence care products were not used as an alternative to providing assistance to a person to toilet.

A review of a Critical Incident (CI) report, submitted to the MOHLTC on an identifed date in 2015, identified that a staff member had not provided assistance to resident #040 when they rang their call bell. Resident #040 was documented to have been provided the requested assistance by the oncoming staff approximately 20 minutes later.
A review of the clinical record between May and August, 2015, of resident #040, indicated that the resident suffered from cognitive impairment and required total assistance with bed mobility, transfer, locomotion, toilet use, personal hygiene and bathing. They were incontinent of their bladder/bowel and wore a brief at all times.

The home's internal investigation record stated PSW #126 responded to the call bell of resident #040 at a specified time on an identified date in 2015. PSW #126 stated the resident required a two (2) person transfer to be toileted and went to ask PSW #125 for assistance. PSW #125 did not provide assistance to toilet resident #040 as they indicated that the resident does not ring the bell for toileting and goes in their brief.

An interview with the Administrator confirmed the licensee failed to ensure that a continence care product was not used as an alternative to providing assistance for resident #040 to be toileted. [s. 51. (2) (e)]

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 continence care products are not used as an alternative to providing assistance to a person to toilet, to be implemented voluntarily.

WN #6: 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 failed to ensure that residents with a change of five (5) percent of body weight, or more, over one (1) month were assessed using interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Resident #012 was at high nutrition risk. On an identified date in 2016, the resident lost a significant amount of weight over one (1) month and on another identified date in 2016, they lost a significant amount of weight over one (1) month. On an identified date in 2016, Inspector #632 interviewed PSW #116 and #117 who confirmed that the weights were to be recorded by the registered staff on a monthly basis and the registered staff were to be informed about significant weight changes. On an identified date in 2016, registered staff #114 confirmed that once re-weighs were confirmed by PSWs, the referrals were to be sent to the Registered Dietitian (RD) for assessment. On the same date in 2016, the RD was interviewed and confirmed that no dietary referrals were submitted and no nutrition assessments were recorded in the resident's plan care. The RD confirmed that the resident with significant weight changes was not assessed using an interdisciplinary approach, and that actions were not taken and outcomes were not evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with a change of five (5) percent of body weight, or more, over one (1) month are assessed using interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was maintained at a minimum temperature of twenty-two (22) degrees Celsius.

On an identified date in 2016, a review of maintenance log records identified that the internal temperature in common rooms on August 23, 2016, (Montrose unit), August 24, 2016, (Stamford unit), August 29, 2016, (Clifton unit), September 13, 2016, (Montrose, Clifton and Stamford units), and on September 30, 2016, (Clifton unit) was twenty-one (21) degrees Celsius and had not been maintained at a minimum of twenty-two (22) degrees Celsius. On November 8, 2016, Maintenance Lead Hand confirmed during the interview that the temperature was recorded below twenty-two (22) degrees Celsius based on the thermostat records. [s. 21.]

WN #8: 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 :

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

On two dates in 2016, Inspector #632 observed that resident # 012 was offered iced water from the morning nourishment cart. A review of the resident’s plan of care and Diet Type Report confirmed that the resident was to be offered an identified snack for their morning snack and that the snack was not available on the cart. An interview with staff #113 and #124 identified that drinks and special nourishments for specific residents' requirements for snacks were prepared and labelled by dietary staff. An interview with the Food and Nutrition Manager (FNM) confirmed that the snack was the planned morning snack for resident #012 and should have been offered to the resident. [s. 71. (4)]

Issued on this 17th day of February, 2017

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

Original report signed by the inspector.