Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 4, 2015	2015_270531_0010	O-001979-15	Resident Quality Inspection

Licensee/Titulaire de permis

AON INC.
33 HARBOUR SQUARE SUITE 825 TORONTO ON M5J 2G2

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

MOIRA PLACE LONG-TERM CARE HOME
415 RIVER STREET WEST TWEED ON K0K 3J0

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

SUSAN DONNAN (531), AMBER MOASE (541), JESSICA PATTISON (197), WENDY BROWN (602)

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): April 20, 21, 22, 23 and 25, 2015.

During the course of the inspection, the inspector(s) spoke with Residents, Resident family members, Personal Support Service Workers, Registered Practical Nurses, Registered Nurses, the RAI Coordinator, the Dietician, the Environmental Support Services Manager, the manager of Resident services, the Director of care and the Administrator.

During the course of the inspection the inspectors conducted a tour of the home, reviewed resident health care records, maintenance program, falls program, skin and wound program, the medication management system and appropriate policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

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

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73. (1) 9 in that residents were not provided with the assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Resident #20 has dementia and is assessed at high nutritional risk. The resident's care plan dated April 2015, states that the resident requires assistance and receives double portions of a pureed diet. His/her last nutritional assessment by the Registered Dietitian on April 14, 2015 indicated that double portions are still not enough to promote weight gain and that 60 mL of a 2.0 supplement will be ordered three times daily. The assessment also indicates that the resident is high nutritional priority related to low body weight and fluid intake frequently below target.

On April 22, 2015, Resident #20 was observed at the lunch meal from 1155 to 1251 hours. Resident #20 was observed to be mixing his/her coffee and juice into his/her pureed meal at approximately 1223 hours. Staff did not appear to notice and the resident continued to mix his/her food without taking a bite. RPN #S120 came to the resident's table at 1229 hours to administer medication to another resident at the table, but did not seem to notice that Resident #20 was mixing his/her food and not eating.

At approximately 1236 hours, the dietary aid came out and got Resident #20 a new meal since she noticed he/she had mixed his/her first meal with his/her coffee and juice. At 1239 hours, the resident began mixing his/her food again. A PSW passed by at 1240 hrs and commented on the resident's "creation" and asked him/her to have a bite but the

resident did not. The resident kept mixing his/her food and the PSW left.

RPN #S120 was then witnessed to crush a medication into Resident #20's dessert and left it at the table with him/her. PSW #S106 noticed the RPN had left the dessert with the medication and sat down and fed it to the resident. He/she ate very well with assistance and finished his/her entire dessert. RPN #S120 then came back and left Resident #20's supplement and he/she poured it onto his/her meal. The PSW left after feeding the resident dessert and did not attempt to assist him/her with his/her fluids or main meal. Resident #20's meal was taken away at 1250 hours, without the resident having taken a single bite.

Review of Point of Care (POC) documentation for April 22, 2015, showed that Resident #20 ate 26-50% of his/her lunch meal and that no setup or physical help was provided during the meal. POC documentation review indicated that from April 1-24, 2015, Resident #20 was provided with one person physical assist at three meals.

During a phone interview with the Registered Dietitian on April 28, 2015, she indicated that what the inspector had observed on April 22, 2015 was not usual for Resident #20 and that she would expect staff to sit and feed the resident if necessary.

Resident #46 has dementia and is assessed at high nutritional risk. The resident's care plan dated April 2015, states that the resident requires assistance and receives double portions of a pureed diet. Specifically the care plan states to provide oversight/encouragement/cueing without physical assistance to eat, however, will need some assistance at meals if he/she is too fatigued/confused to eat. Staff may need to put cups in his/her hands to initiate drinking independently.

A review of Resident #46's nutritional assessments showed that in January 2015 the resident had experienced a significant weight change of 3.9 kg over one month. The resident had changed home areas and the RD assessment indicated that the resident was receiving somewhat less assistance at meals. The RD indicated that Resident #46 can participate in the feeding process, but he/she requires significant assistance to consume sufficient quantities to promote weight gain. Another assessment completed by the RD on February 2015, indicated that with increased assistance at meals and return to double portions, the resident's weight had increased a modest amount over 1 month. The most recent nutritional assessment dated March 2015 by the RD, indicated that the resident's current weight remains well below his/her ABW (adjusted body weight) range with a Body Mass Index of 17 and that the care plan is developed with a goal of

promoting an ongoing pattern of weight gain.

On April 20, 2015, Resident #46 was observed at the lunch meal. The resident sat in a chair in the dining room with a tray that slides over the arms. At approximately 1230 hrs, Resident #46 spilled his/her glass of milk on himself/herself. The tray on the chair did not appear to fit properly at the time. Staff made some adjustments to the chair and then gave the resident his/her meal on a small rubber square to stop the plate from sliding. At this time the tray was angled back towards the resident and he/she appeared to be having a hard time feeding himself/herself. The resident was rocking back and forth trying to feed himself/herself when the tray fell off and his/her lunch was spilled on the floor. A staff member in the dining room was then overheard to say “did he/she make another mess?" Resident #46 was given another drink while staff cleaned up his/her meal. The resident was not offered another meal or a dessert and his/her shirt saver was removed by staff at 1309 hours.

On April 22, 2015, Resident #46 was observed at the lunch meal. The resident received total feeding assistance with his/her meal by one staff member and appeared to eat 100% of his/her meal. During this dining observation it was noted that three PSW students were providing additional assistance in the dining room.

On April 23, 2015, Resident #46 was observed at the lunch meal. The resident sat in a chair, but instead of a tray over the arms of the chair, he/she was given his/her meal on a tray with wheels. The resident ate his/her soup independently and started on his/her meal approximately 1222 hours. Resident #46 started to have difficulty at 1229 hrs. He/she had food on his/her hands and stopped eating. At 1234 hours the resident pushed the tray away with his/her feet. At 1235 hrs, PSW #S106 brought the resident a spoon and he/she began to eat again. At about 1238 hours, the resident started to spill his/her main meal down the front of his/her shirt saver due to the fact that he/she was pushing the tray away with his/her feet and then would drop food on his/her shirt trying to bring the spoon to his/her mouth. At 1243 hours, Resident #46’s meal was taken off his/her tray with about 30% still remaining. Staff did not attempt to assist the resident with the remainder of his/her meal. Dessert was then provided to the resident, but again, no staff assistance or oversight was provided. The resident continued to spill his/her dessert down the front of him/her since he/she kept pushing the tray further away with his/her feet. At one point a PSW did come to push the tray back in for him/her, but no physical assistance was provided.

An interview was conducted with PSW #S115 on April 24, 2015 by Inspector #541. S115

indicated that the amount of feeding assistance for Resident #46 varies day by day. If he/she is very alert he/she can feed himself, although he/she is messy. Other times he/she is totally dependent and requires staff to feed him/her. S115 indicated that if you're not sitting with Resident #46, he/she should not eat with the tray that fits over the arms of the chair because he/she will push it off and spill his/her food. S115 stated that the chairs themselves will move back and forward causing the tray to be tilted and food will slide off.

During a phone interview with the Registered Dietitian on April 28, 2015, she indicated that Resident #46 had a significant weight loss in January 2015 and is currently receiving a nutritional supplement and double portions to promote weight gain. The RD also stated that the resident will do a significant amount of eating on his/her own, but that staff are supposed to assist the resident at the end of the meal since he/she will sometimes get tired or confused. She stated that she would expect staff to assist him/her if he/she is struggling to feed himself/herself since the resident likes his/her meals and will eat 100% with sufficient assistance.

Resident #14 has a diagnosis of unspecified dementia.

According to Resident #14's nutritional care plan updated by the Registered Dietitian (RD) on April 2015, Resident #14 is at high nutritional risk due to poor intake at meals and significant weight loss. Interventions on the current nutritional care plan indicate Resident #14 requires one staff to provide assistance to eat and may assist with beverages but will usually need them placed in his/her hand.

According to a nutritional note written on March 2015 the RD assessed Resident #14 and indicated he/she required total assistance on that day during lunch meal but was able to manage fluids on his/her own.

On April 2015 another assessment was completed by the RD indicating Resident #14 has had a significant weight loss of 5.1% over the past month. This assessment indicates Resident #14 has had a decrease in his/her food intake at meals and is no longer feeding himself/herself, he/she usually requires extensive assistance. The assessment indicated cuing and encouragement are generally not effective.

On April 20, 2015 Inspector #197 observed lunch meal service on the secure unit. At 1243 hrs Resident #14 was observed to be sitting looking straight ahead and had not touched his/her meal since 1230 hrs. No staff were present to provide encouragement or

assistance. At 1249 hrs Resident #14's plate was removed with most of the food still on it. At this time, resident had a chocolate drink and a dessert in front of him/her which he/she did not touch and no assistance was provided. At 1300 hrs Resident #14 started to slowly eat his/her dessert however staff removed the dessert before resident was done eating and started to wash his/her hands.

On April 22, 2015 Inspector #541 observed the lunch meal service on the secure unit. It was noted there were three Personal Support Worker (PSW) students as well as three PSWs in the dining room throughout the meal service. At 1217 hrs Resident #14 was provided with his/her juice, no staff member provided assistance. At 1224 hrs Resident #14 was provided with his/her entrée. Between 1224 - 1232 hrs a PSW student and the Food Service Manager each asked Resident #14 if he/she was going to eat something, resident replied no however no further encouragement or assistance was provided. No physical assistance was provided to Resident #14 and at 1239 hrs PSW staff member #S114 removed the entrée from Resident #14 and provided him/her with dessert. No assistance was provided for Resident #14 to eat his/her dessert until 1243 hrs. This assistance was provided by PSW student who was assisting two other residents at Resident #14's table who require total assistance.

On April 23, 2015 Inspector #541 again observed the lunch meal service on the secure unit. At 1210 and 1216 hrs respectively, Resident #14 was provided with his/her soup and juice, no assistance was provided. At 1225 hrs a Speech Language Pathologist (SLP) approached Resident #14 to assess him/her. The SLP tried to encourage Resident #14 to eat but was unsuccessful. The SLP did provide physical assistance for one bite of soup only. At 1227 hrs PSW staff member #115 removed the soup from Resident #14 and provided him/her entrée. No assistance was provided by staff to help Resident #14 eat until 1248 hrs when PSW staff member #S115 did sit next to Resident #14 to encourage him/her to eat. Resident #14 took one bite of his/her meal, staff member left resident and no further assistance was provided.(541) [s. 73. (1) 9.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73. (2) (b) in that residents who require assistance with eating and drinking were served before someone was available to provide assistance.

Resident #44 has a diagnosis of Alzheimer's disease.

Resident #44's nutritional care plan effective March 2015 states he/she requires oversight/encouragement/cueing to eat however sometimes may require physical

assistance.

On April 20, 2015 at 1230 hrs. Inspector #197 observed Resident #44 with his/her plate in front of him/her with no assistance provided, unsure how long Resident's plate of food was in front of him/her prior to this time. Resident #44 did not make any attempts to feed himself/herself. At 1233 hrs PSW staff member #S106 apologized to Resident #44, took his/her plate to reheat then provided him/her with feeding assistance.

On April 23, 2015 Inspector #541 interviewed PSW staff members #S114 and #S108 who both indicated Resident #44 requires assistance to eat but sometime will not accept the assistance from staff. Both staff members indicated Resident #44 has declined recently.

A food and fluid intake report for Resident #44 indicates that during the lunch meal on April 20, 22 and 23, 2015 Resident required one person physical assist to eat. It was noted during the dining observation that Resident #44 was not provided with assistance until 30 minutes after meal was provided. (541)

Resident #43 is diagnosed with dementia and is assessed by the Registered Dietitian as high nutritional priority due to gradual weight loss.

Resident #43's care plan dated April 13, 2015 indicates that he/she requires assistance at meals ranging from encouragement/cueing to extensive assistance to consume all food and fluid.

Inspector #541 conducted interviews with PSW's #S115 and #S108 on April 24, 2015 regarding feeding assistance for Resident #43. S115 stated that it depends on the day what kind of feeding assistance the resident requires. He/she indicated that the resident has been lethargic and sleepy the last few days and so staff had to provide total feeding assistance. S108 stated that Resident #43 requires extensive to total feeding assistance.

On April 22, 2015, the lunch meal was observed on the Heritage home area. It was noted that at 1207 hrs, soup had been distributed to all residents in the dining room. Resident #43 was sitting with his/her soup in front of him/her and did not make an attempt to feed himself/herself. At 1220 hours (13 minutes later), a staff member sat down to assist Resident #43 with his/her soup and then his/her main meal. Dessert was distributed and served to Resident #43 at 1243 hours. Again, the resident did not attempt to feed himself/herself. At 1251 hours (8 minutes later), a staff member sat down to assist the

resident with his/her dessert.

Resident #43 and #44, residents who require assistance with their meals, were served before someone was available to provide assistance. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, 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 has failed to comply with O. Reg. 79/10 r. 8. (1) (b) whereby the medication administration policy and procedures were not complied with.
O. Reg. 79/10, s. 114(2) states the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The homes Medication Administration Policy and Procedure (policy number RS-E-30) states the following:
Procedure: Preparing the medication:
Registered staff will:
#12. Give the medication immediately after preparing it. Stay with the resident to ensure that the resident takes the medication safely and completely. Provide the resident with a drink prior to taking the medication to lubricate the mouth and throat. An intake of 200ml of fluid is needed for most oral medications to be dissolved and absorbed.

On April 22, 2015 at approximately 1240 hrs, RPN #S120 was observed to take Resident #20's pureed dessert to the medication cart and then brought it back and left it on the table in front of the resident and walked away. It appeared that Resident #20's medication had been crushed and mixed into his/her dessert. PSW #S106 noticed that the RPN had left the dessert with the resident and sat down with the resident to feed it to him/her. It was noted on this day that Resident #20 did not eat or drink independently and required assistance since he/she was constantly mixing his/her food and drinks together without taking a bite. RPN #S120 was then observed leaving Resident #20's nutritional supplement in front of him/her, which he/she then dumped into his/her meal before the PSW could assist him/her.

On April 23, 2015 at approximately 1245 hrs, RPN #S101 was observed to take Resident #15's dessert to the medication cart and then brought it back and left it with the resident. The Inspector closely observed the dessert and was able to see crushed medication sprinkled on top. RPN #S101 did not stay with Resident #15 to ensure he/she consumed all of his/her dessert/medication.

On April 25, 2015 the Administrator was interviewed and confirmed that the policy was not complied with. [s. 8. (1)]

Issued on this 5th day of May, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN DONNAN (531), AMBER MOASE (541), JESSICA PATTISON (197), WENDY BROWN (602)
Inspection No. / No de l'inspection :	2015_270531_0010
Log No. / Registre no:	O-001979-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 4, 2015
Licensee / Titulaire de permis :	AON INC. 33 HARBOUR SQUARE, SUITE 825, TORONTO, ON, M5J-2G2
LTC Home / Foyer de SLD :	MOIRA PLACE LONG-TERM CARE HOME 415 RIVER STREET WEST, TWEED, ON, K0K-3J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHAEL O'KEEFFE

To AON INC., 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. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

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

Order / Ordre :

The licensee shall ensure the following:
- Residents on the Heritage home area are assessed, and reassessed as required, to ensure that adequate feeding assistance is provided to residents who require assistance.
- Regular monitoring in the Heritage home area dining room during lunch meal service to ensure appropriate assistance and supervision of residents. Updates shall be reported through the home's quality improvement and utilization review system, as required under the LTCHA 2007, s. 84.
- Residents are provided with appropriate eating aids and assistive devices so that they may safely eat and drink as comfortably and independently as possible.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73. (1) 9 in that residents were not provided with the assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Resident #20 has dementia and is assessed at high nutritional risk. The resident's care plan dated April 2015, states that the resident requires assistance and receives double portions of a pureed diet. The resident's last nutritional assessment by the Registered Dietitian on April 2015 indicated that double portions are still not enough to promote weight gain and that 60 mL of a 2.0 supplement will be ordered three times daily. The assessment also indicates that the resident is high nutritional priority related to low body weight and fluid intake frequently below target.

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him/her to have a bite but the resident did not. The resident kept mixing his/her food and the PSW left.

RPN #S120 was then witnessed to crush a medication into Resident #20's dessert and left it at the table with the resident. PSW #S106 noticed the RPN had left the dessert with the medication and sat down and fed it to the resident. He/she ate very well with assistance and finished his/her entire dessert. RPN #S120 then came back and left Resident #20's supplement and he/she poured it onto his/her meal. The PSW left after feeding the resident dessert and did not attempt to assist him/her with his/her fluids or main meal. Resident #20's meal was taken away at 1250 hrs, without the resident having taken a single bite.

Review of Point of Care (POC) documentation for April 22, 2015, showed that Resident #20 ate 26-50% of his/her lunch meal and that no setup or physical help was provided during the meal. POC documentation review indicated that from April 1-24, 2015, Resident #20 was provided with one person physical assist at three meals.

During a phone interview with the Registered Dietitian on April 28, 2015, she indicated that what the inspector had observed on April 22, 2015 was not usual for Resident #20 and that she would expect staff to sit and feed the resident if necessary.

Resident #46 has dementia and is assessed at high nutritional risk. The resident's care plan dated April 2015, states that the resident requires assistance and receives double portions of a pureed diet. Specifically the care plan states to provide oversight/encouragement/cueing without physical assistance to eat, however, will need some assistance at meals if he/she is too fatigued/confused to eat. Staff may need to put cups in his/her hands to initiate drinking independently.

A review of Resident #46's nutritional assessments showed that in January 2015 the resident had experienced a significant weight change of 3.9 kg over one month. The resident had changed home areas and the RD assessment indicated that the resident was receiving somewhat less assistance at meals. The RD indicated that Resident #46 can participate in the feeding process, but he/she requires significant assistance to consume sufficient quantities to promote weight gain. Another assessment completed by the RD on February 2015, indicated that with increased assistance at meals and return to double

portions, the resident's weight had increased a modest amount over 1 month. The most recent nutritional assessment dated March 2015 by the RD, indicated that the resident's current weight remains well below his/her ABW (adjusted body weight) range with a Body Mass Index of 17 and that the care plan is developed with a goal of promoting an ongoing pattern of weight gain.

On April 20, 2015, Resident #46 was observed at the lunch meal. The resident sat in a chair in the dining room with a tray that slides over the arms. At approximately 1230 hrs, Resident #46 spilled his/her glass of milk on him/herself. The tray on the chair did not appear to fit properly at the time. Staff made some adjustments to the chair and then gave the resident his/her meal on a small rubber square to stop the plate from sliding. At this time the tray was angled back towards the resident and he/she appeared to be having a hard time feeding him/herself. The resident was rocking back and forth trying to feed himself/herself when the tray fell off and his/her lunch was spilled on the floor. A staff member in the dining room was then overheard to say "did he/she make another mess?" Resident #46 was given another drink while staff cleaned up his/her meal. The resident was not offered another meal or a dessert and his/her shirt saver was removed by staff at 1309 hrs.

On April 22, 2015, Resident #46 was observed at the lunch meal. The resident received total feeding assistance with his/her meal by one staff member and appeared to eat 100% of his/her meal. During this dining observation it was noted that three PSW students were providing additional assistance in the dining room.

On April 23, 2015, Resident #46 was observed at the lunch meal. The resident sat in a chair, but instead of a tray over the arms of the chair, he/she was given his/her meal on a tray with wheels. The resident ate his/her soup independently and started on his/her meal about approximately 1222 hrs. Resident #46 started to have difficulty at 1229 hrs. Resident #46 had food on his/her hands and stopped eating. At 1234 hrs the resident pushed the tray away with his/her feet. At 1235 hrs, PSW #S106 brought the resident a spoon and he/she began to eat again. At about 1238 hrs, the resident started to spill his/her main meal down the front of his/her shirt saver due to the fact that he/she was pushing the tray away with his/her feet and then would drop food on his/her shirt trying to bring the spoon to his/her mouth. At 1243 hrs, Resident #46's meal was taken off his/her tray with about 30% still remaining. Staff did not attempt to assist the resident with the remainder of his/her meal. Dessert was then provided to the resident,

but again, no staff assistance or oversight was provided. The resident continued to spill the dessert down the front of him/her since he/she kept pushing the tray further away with his/her feet. At one point a PSW did come to push the tray back in for him/her, but no physical assistance was provided.

An interview was conducted with PSW #S115 on April 24, 2015 by Inspector #541. S115 indicated that the amount of feeding assistance for Resident #46 varies day by day. If he/she is very alert he/she can feed himself/herself, although he/she is messy. Other times Resident #46 is totally dependent and requires staff to feed him/her. S115 indicated that if you're not sitting with Resident #46, he/she should not eat with the tray that fits over the arms of the chair because he/she will push it off and spill his/her food. S115 stated that the chairs themselves will move back and forward causing the tray to be tilted and food will slide off.

During a phone interview with the Registered Dietitian on April 28, 2015, she indicated that Resident #46 had a significant weight loss in January 2015 and is currently receiving a nutritional supplement and double portions to promote weight gain. The RD also stated that the resident will do a significant amount of eating on his/her own, but that staff are supposed to assist the resident at the end of the meal since he/she will sometimes get tired or confused. She stated that she would expect staff to assist Resident #46 if he/she is struggling to feed himself/herself since the resident likes his/her meals and will eat 100% with sufficient assistance.

Resident #14 has a diagnosis of unspecified dementia.

According to Resident #14's nutritional care plan updated by the Registered Dietitian (RD) on April 2015, Resident #14 is at high nutritional risk due to poor intake at meals and significant weight loss. Interventions on the current nutritional care plan indicate Resident #14 requires one staff to provide weight bearing assistance to eat and may assist with beverages but will usually need them placed in his/ her hand.

According to a nutritional note written on March 2015 the RD assessed Resident #14 and indicated he/she required total assistance on that day during lunch meal but was able to manage fluids on his/her own.

On April 2015 another assessment was completed by the RD indicating

Resident #14 has had a significant weight loss of 5.1% over the past month. This assessment indicates Resident #14 has had a decrease in his/her food intake at meals and is no longer feeding himself/ herself, he/she usually requires extensive assistance. The assessment indicated cuing and encouragement are generally not effective.

On April 20, 2015 Inspector #197 observed lunch meal service on the secure unit. At 1243 hrs Resident #14 was observed to be sitting looking straight ahead and had not touched his/her meal since 1230 hrs. No staff were present to provide encouragement or assistance. At 1249 hrs Resident #14's plate was removed with most of the food still on it. At this time, resident had a chocolate drink and a dessert in front of him/her which he/she did not touch and no assistance was provided. At 1300 hrs Resident #14 started to slowly eat the dessert however staff removed the dessert before resident was done eating and started to wash his/her hands.

On April 22, 2015 Inspector #541 observed the lunch meal service on the secure unit. It was noted there were three Personal Support Worker (PSW) students as well as three PSWs in the dining room throughout the meal service. At 1217 hrs Resident #14 was provided with juice, no staff member provided assistance. At 1224 hrs Resident #14 was provided with his/her entrée. Between 1224 - 1232 hrs a PSW student and the Food Service Manager each asked Resident #14 if he/she was going to eat something, resident replied no however no further encouragement or assistance was provided. No physical assistance was provided to Resident #14 and at 1239 hrs PSW staff member #S114 removed the entrée from Resident #14 and provided him/her with dessert. No assistance was provided for Resident #14 to eat the dessert until 1243 hrs. This assistance was provided by PSW student who was assisting two other residents at Resident #14's table who require total assistance.

On April 23, 2015 Inspector #541 again observed the lunch meal service on the secure unit. At 1210 and 1216 hrs respectively, Resident #14 was provided with his/her soup and juice, no assistance was provided. At 1225 hrs a Speech Language Pathologist (SLP) approached Resident #14 to assess him/her. The SLP tried to encourage Resident #14 to eat but was unsuccessful. The SLP did provide physical assistance for one bite of soup only. At 1227 hrs PSW staff member #115 removed the soup from Resident #14 and provided him/her entrée. No assistance was provided by staff to help Resident #14 eat until 1248 hrs when PSW staff member #S115 did sit next to Resident #14 to encourage

him/her to eat. Resident #14 took one bite of his/her meal, staff member left resident and no further assistance was provided.(541)

(197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Donnan

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