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
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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
Dec 18, 2015	2015_183128_0023	031635-15	Complaint

Licensee/Titulaire de permis

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

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

THE VILLAGE OF GLENDALE CROSSING
3030 Singleton Avenue LONDON ON N6L 0B6

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

RUTH HILDEBRAND (128)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 24 - 27, 30 and December 1, 2015. suggest summarizing- provision of resident care, reporting and complaints, personal support services etc.

This complaint inspection was related to numerous concerns with one identified resident including: provision of resident care, nutrition and hydration, personal support services, physiotherapy, medications, recreation and reporting and complaints.

During the course of the inspection, the inspector(s) spoke with the General Manager, Administrative Assistant, Director of Nursing, Assistant Director of Nursing, one Neighbourhood Coordinator, Resident Assessment Instrument/Quality Improvement Coordinator, six registered practical nurses (RPN), seven personal support workers (PSW), one personal support worker student, one Recreation Coordinator, Director of Food Services, registered dietitian, one food service worker, one identified resident and three family members.

The inspector observed an identified resident and the care provided, resident-staff interactions, meals provided to the identified resident and evening snack service on one neighbourhood, the health care record and plan of care for the identified resident, food and fluid documentation records for residents on the neighbourhood, menus related to the inspection, food production for snack service, staffing schedule and criminal reference check for one staff member, posting of required information, complaints and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Snack Observation

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

14 WN(s)
9 VPC(s)
9 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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).

Findings/Faits saillants :

1. The home has a history of non-compliance with plans of care not providing clear direction:

A written notification and a voluntary plan of correction were previously issued September 15, 2015, under Log # 024284-15 and inspection #2015_217137_0040.

A written notification and a voluntary plan of correction were previously issued October 2, 2014 under Log # 004625-14 and inspection #2014_303563_0037.

A written notification and a voluntary plan of correction were previously issued February 5, 2013 under Log # L-00077-13 and 2013_186171_0005.

The licensee has failed to ensure that the plan of care set out clear directions to staff

and others who provided direct care to the resident.

A. A review of the plan of care revealed that it did not provide clear direction in terms of the amount of personal assistance and encouragement resident #001 required to safely eat and drink as comfortably and independently as possible.

The clinical record revealed that the resident was at high nutritional risk and was 7.7 kilograms below the identified goal weight range.

The personal care profile, located in the dietary binder in a servery, was reviewed and it was noted that it indicated that resident #001 required "total assistance with eating/feed all meal". The profile had an identified date.

A personal support worker questioned Inspector #128, on an identified date, in regard to whether staff had to stay with resident #001 while the resident was eating if family was present. The personal support worker indicated that staff found it difficult to stay with resident #001 when meal service was happening in the dining room.

A registered practical nurse questioned Inspector #128, the next day, in regard to whether the staff were required to stay with the resident throughout each meal. The registered practical nurse indicated that one family member indicated that he/she did not want to assume responsibility while the resident was eating.

A review of the activities of daily living functional rehab potential/restorative care plan resident assessment protocol(RAP), with an identified date, indicated that staff were to stay with resident #001 when the resident ate for safety.

The care plan developed by the registered dietitian indicated that resident #001 was to be provided cueing to complete meals.

The activities of daily living care plan, indicated under eating/dehydration that resident #001 required “++ motivation to eat”.

The personal expressions care plan indicated interventions for resident #001 if resident did not come for lunch or displayed responsive behaviours.

The Director of Nursing indicated in an interview that staff had been given direction that they were to stay with resident #001 at all times throughout the meal, unless the family

wanted to assume care for the resident during the meal.

The Director of Food Services indicated that resident #001 did not require total assistance with eating or to be fed all meals. She indicated that the plan of care should be consistent and provide clear direction to staff.

B. A review of the plan of care revealed that it did not provide clear direction in terms of the diet that resident #001 was to receive.

A review of the clinical record revealed that the activities of daily living functional rehab potential/restorative care plan RAP, with an identified date, indicated that resident #001's current diet order was regular diet, minced texture, thickened fluids.

It was noted that the diet list in a neighbourhood servery and the high nutritional risk care plan in the clinical record indicated that the resident was on a regular/regular/regular diet.

The activities of daily living care plan indicated under eating/dehydration that resident #001 was on a minced texture, regular fluids(sips), regular diet.

The registered dietitian indicated during an interview that there should only be reference to one diet in the plan of care and confirmed that the plan of care should provide clear direction to staff.

C. A review of the plan of care revealed that it did not provide clear direction, for resident #001, in terms of bathing.

The activities of daily living care plan indicated that resident #001 was to receive a bed bath twice a week, on specified days.

An identified neighbourhood bathing schedule indicated that resident #001 was to be bathed on the evening shift on different days.
The personal care plan also used by the personal support workers to provide care indicated that the resident was to be bathed on the day shift on the days specified in the activities of daily living care plan.

A personal support worker confirmed that the plan of care did not provide clear direction related to bathing. The personal support worker indicated that staff have not been able to bathe resident #001 on day shift "in a long time".

The Director of Nursing confirmed that the expectation was that the plan of care provided clear direction to staff and that it should be consistent throughout the plan of care.

D. A review of the plan of care, for resident #001, revealed that it did not provide clear direction in terms of dressing.

The plan of care for resident #001 revealed that the activities of daily living functional rehabilitation/restorative care plan RAP, with a specified date, identified that staff needed to assist resident #001 with dressing. It noted resident was able to assist with dressing on occasion. He/she did require assistance with putting on his/her pants and socks, doing up buttons and zippers.

The activities of daily living care plan indicated that resident #001 required total assistance with dressing. Staff were required to put on pants and shoes. The resident was able to assist with the shirt by putting arms through sleeves, however would frequently opt not to help.

During an interview two personal support workers indicated that resident #001 had not been dressed for approximately five months as the resident wore night clothes. A registered practical nurse present for the interview also confirmed that it had been at least five months since the resident had been fully dressed because the resident's shoulder was too painful to get dressed.

The Director of Nursing confirmed that the expectation was that the plan of care provided clear direction to staff and that it should be consistent throughout the plan of care.

E. A review of the plan of care, for resident #001, revealed that it did not provide clear direction in terms of safety devices required, personal assistance required for transferring and ability to walk.

The activities of daily living care plan, with an identified date, indicated in the transferring and falls prevention sections that resident #001 was to have safety measures in place as the resident "will forget to call for assistance with transferring". It also indicated that the resident required the use of an assistive device for all transfers.

A personal support worker confirmed that the plan of care did not provide clear direction related to safety devices. The personal support worker indicated that neither of the safety

devices identified were used for resident #001.

The personal care plan used by the personal support workers to provide care indicated that the resident's transfer status was one person assist (limited), ensure safety device was active, and the resident walked with a walker.

The resident was observed either in bed or in a wheelchair throughout the inspection.

Two personal support workers were observed transferring resident #001 with an assistive device, on an identified date and indicated that the resident needed to be transferred using an assistive device.

The kinesiologist indicated in an interview that resident #001 was no longer able to walk and used a wheelchair.

The Director of Nursing confirmed that the expectation was that the plan of care provided clear direction to staff and that it should be consistent throughout the plan of care.

F. A review of the plan of care revealed that it did not provide clear direction in terms of the amount of fluid resident #001 was to be provided.

The high nutritional risk care plan revealed that the resident was to be provided and encouraged an identified amount of fluids at snacks.

The personal care profile, located in the dietary binder in an identified servery, was reviewed and it was noted that it indicated that resident #001 was to be provided an identified beverage in a specific quantity at each snack and that at afternoon snack the resident was to receive two of the identified beverages.

The diet list that was to be used on the snack cart indicated the identified beverage for the afternoon snack but the quantity was not specified.

On an identified date, a personal support worker was observed with one of the identified beverages for resident #001. The resident was sleeping so was not provided with any beverages at the afternoon snack that day.

The Director of Nursing confirmed that the expectation was that the plan of care provided clear direction to staff and that it should be consistent throughout the plan of care.

The severity of the plan of care not providing clear direction was determined to be potential for harm and the scope of the issue was isolated to one resident with six areas of the plan of care not providing clear direction. The home had a history of related and multiple unrelated non-compliance. [s. 6. (1) (c)]

2. The home has a history of non-compliance with plans of care not being provided:

A written notification and a voluntary plan of correction were previously issued May 27, 2015, under Log # 008040-15 and inspection #2015_259520_0017.

A written notification and a voluntary plan of correction were previously issued August 1, 2013 under Log # L-000584-13 and #L-000531-13 and inspection #2013_229213_0022.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan in regard to pain assessments, orders for supplements and the recreation plan of care.

A. A review of the medication administration record (MAR), for resident #001, revealed the resident was to have a weekly pain assessment. It indicated "assess pain, attach vital and document in pain binder".

A review of the pain binder revealed that there was no evidence to support that any weekly pain assessments had been completed in an identified four month time frame.

A review of resident #001's hard copy chart also revealed no evidence to support that any pain assessments had been completed during the four months.

Medication administration records were reviewed for the identified four months. During that 17 week period it was noted that six pain assessments had been completed on the medication administration record.

A registered practical nurse, on the identified neighbourhood confirmed that 11/17 (65%) pain assessments had not been completed on the medication administration record. The registered practical nurse also confirmed that there were no pain assessments in the hard copy clinical record for the resident and that there were no pain assessments in the pain binder in that four month time frame.

The Director of Nursing indicated that the expectation was that the resident's plan of care should have been followed and if the resident was to have pain assessments completed weekly, with documentation in the pain binder, then that was what should have happened.

B. A review of the three month medication review, for resident #001, during an identified three month time frame, revealed an order for a supplement three times per day at three specific times with med pass.

The clinical record revealed that the resident was at high nutritional risk and was 7.7 kilograms below the identified goal weight range.

On an identified date, resident #001 was observed in bed in his/her room. A registered practical nurse was observed attempting to give the resident his/her medications. The resident indicated that he/she did not wish to take the medication. The supplement was left sitting on the table beside the resident's lunch.

One hour and 23 minutes later, resident #001 was observed in bed asleep and the supplement was observed sitting untouched on the table.

At the next meal, a registered practical nurse was observed administering a supplement to resident #001 who was in bed at the time. Inspector #128 asked the registered practical nurse what he/she had done with the other supplement from lunch. He/she indicated that he/she had thrown it out and confirmed that the previous supplement was not provided to the resident.

A review of the medication administration record, for resident #001, the next day, revealed that the supplement from the previous day was signed as being given to the resident 21 minutes after it was refused by the resident and subsequently thrown out.

A registered practical nurse was questioned about the amount of supplement being given to resident #001. The registered practical nurse indicated that 90 millilitres of supplement was being provided and indicated that registered staff always gave the supplement in the dixie cup being used.
Inspector #128 measured the equivalent amount of water in the dixie cup and determined that approximately 70 millilitres was the amount of supplement being given. The registered practical nurse confirmed that only 70 millilitres was being provided to the

resident. The registered practical nurse indicated that the dixie cup glass only held 90 millilitres so they couldn't fill it to the brim or it would spill on the resident. The registered practical nurse confirmed that the supplement was not being provided as per the plan of care and acknowledged that it was routinely signed for as 90 millilitres of supplement not the actual 70 millilitres.

The registered dietitian indicated, during an interview, that she had written the order for the supplement to be given to the resident and the expectation was that the plan of care was followed. She indicated that if 90 millilitres didn't fit in the dixie cups used to dispense the supplement then her expectation was that a larger glass would be used.

C. A review of the three month medication review, for resident #001, for a specified three month period revealed an order for a supplement, one package three times per day in juice.

The clinical record revealed that the resident was at high nutritional risk and was 7.7 kilograms below the identified goal weight range.

Observations of resident #001, on an identified date, revealed that the resident did not have juice with the supplement in it prior to the supper meal.

A personal support worker confirmed, at 11:50 that day, that the resident had only had two sips of regular juice all morning.

Observation of the noon meal tray revealed that there was no supplement in the juice. Three personal support workers confirmed, at 13:50, that they had not given any supplement to the resident that day. One of the personal support workers indicated that the registered staff usually gave the personal support workers the supplement to put in the juice.

A fourth personal support worker confirmed at 16:12, that resident #001 did not have an afternoon beverage or snack.

A review of the medication administration record, for resident #001, the next day, revealed that the supplement was signed as being given to the resident at 13:26, the previous day.

The registered dietitian indicated, during an interview, that she had written the order for

the supplement to be given to the resident and the expectation was that the plan of care was provided.

D. A review of the plan of care for resident #001, revealed that the care plan indicated that resident #001 would like a one to one visit more than a group program. The care plan goal indicated "provide a one to one visit a week". The care plan also indicated that the resident would participate in other group programs occasionally.

A review of the multi-month participation report revealed that resident #001 had attended three activities, including two one to one visits, in one identified month. Zero activities were attended in the next month and four activities, with no one to one visits were attended the following month.

A Recreation Coordinator acknowledged that she/he tried to do two or three one to one visits, per month with resident #001 but they were not always documented. She/he indicated that one to one visits were not always completed if resident #001 attended a group activity instead. The Recreation Coordinator acknowledged that the documentation reflected that there were three activities in the identified month, zero activities in the next month and four activities in the following, with two one to one visits in the three month period.

The General Manager indicated that the expectation was that the care set out in the plan of care for each resident was provided to the resident as specified in the plan of care, including the personal recreation and well-being plan of care.

The severity of the plan of care not being provided was determined to be potential for harm as the resident is at high nutritional risk. The scope of the issue was a pattern. The home had a history of related and multiple unrelated non-compliance. [s. 6. (7)]

3. The licensee has a history of non-compliance with plan of care being reviewed and revised:

A written notification was previously issued March 4, 2013 under Log #L-000088-13, L-000095-13, L-000095-13 and L-000109-13 and Inspection #2013_185112_0019.

The licensee has failed to ensure that when each resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan was not effective.

A clinical record review revealed that the resident assessment protocol(RAP), in GoldCare, indicated that resident #001 displayed responsive behaviours.

The functional rehab/restorative care plan RAP indicated that resident #001's involvement in participating with his/her activities varied on his/her mood that day.

A review of the current GoldCare progress notes revealed that there was ongoing documentation, as well as notes on three identified dates and twice on a fourth date, in regard to the resident's responsive behaviours.

During interviews two personal support workers and a registered practical nurse indicated that resident #001 has had " behaviours" since admission, approximately five years ago, but indicated the responsive behaviours have "progressively gotten worse". Six personal support workers and four registered practical nurses expressed concerns related to behaviours exhibited by the resident.

The care plan, with an identified date, indicated that there were interventions related to the resident's responsive behaviours.

The General Manager indicated that resident #001 had "one good day every 60 days".

A registered practical nurse confirmed that the home did not do daily observation sheet (DOS) charting to demonstrate the frequency, severity, patterns of behaviours for resident #001. The registered practical nurse indicated that they only did DOS charting when requested for abnormal behaviours.

Despite, ongoing documentation of resident #001 demonstrating responsive behaviours, there was no evidence to support that the resident was being supported by the home's Behavioural Support Ontario (BSO) team.
An interview was conducted with the Director of Nursing present and the BSO lead for an identified neighbourhood. The registered practical nurse/ BSO team lead indicated that a referral had not been sent for resident #001 since he/she commenced the position. The team lead indicated no awareness of resident #001 ever being followed by the BSO team. The registered practical nurse indicated that as far as he/she was aware, the neighbourhood was "managing the behaviours well".

A clinical record review revealed that resident #001 had been seen by the Specialized Geriatric Services/Regional Geriatric Program for medical issues, on a specified date, but

a referral had not been made for behavioural concerns.
The General Manager confirmed that the referral on the specified date had been related to medical issues.

The General Manager acknowledged that the care set out in the plan of care had not been effective related to responsive behaviours and that it needed to be reviewed and revised.

The severity of the resident not being reassessed when the care was not effective was determined to be actual harm related to the outcome negatively affecting the resident's ability to achieve his/her highest functional status. The scope of the issue was isolated. The home had a history of related and multiple unrelated non-compliance. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home has a history of non-compliance with policies not being complied with:

A written notification and a voluntary plan of correction were previously issued October 6, 2015, under Log # 024636-15, #024664-15, and # 027147-15 and inspection #2015_262523_0027.

A written notification and a voluntary plan of correction were previously issued October 6, 2015, under Log # 027142-15 and inspection #2015_262523_0026.

A written notification and a compliance order were previously issued September 15, 2015, under Log # 024284-15 and inspection #2015_217137_0040.

A written notification and a voluntary plan of correction were previously issued December 18, 2014 under Log # 009192-14 and inspection #2014_263524_0044.

A written notification and a voluntary plan of correction were previously issued November 24, 2014 under Log # L-001536-14 and inspection #2014_216144_0063.

A written notification was previously issued August 1, 2013 under Log # L-000584-13 and #L-000531-13 and inspection #2013_229213_0022.

A written notification and a voluntary plan of correction were previously issued July 2, 2013 under Log #L-000333-13 and inspection #2013_183135_0027.

The licensee has failed to ensure that policies related to diet terminology, nutrition and hydration and hand hygiene were complied with.

A. A review of the policy entitled Hand Hygiene, Tab 10-13, from the Infection Prevention and Control Manual; dated April 2014, revealed that the "4 Moments for Hand Hygiene" were expected to be used when working with residents. It identified that staff were expected to use hand hygiene before contact with a resident or their environment, before aseptic procedures, after body fluid exposure risk and after resident or resident environment contact.

During the evening snack observation, on an identified date, it was noted that the personal support worker serving snack to residents was not using hand washing/hand hygiene between residents. The personal support worker was observed touching potentially dirty door handles to resident rooms, assisting residents, repositioning residents, and picking up dirty glasses. The personal support worker was noted to use hand sanitizer once during the time that 12 residents were served snack.

The personal support worker acknowledged that hand sanitizer/hand hygiene should

have been used between residents and also acknowledged that he/she had used hand sanitizer only once during the serving of snack to 12 residents.

The Director of Nursing indicated that the expectation was that staff use the "4 moments for hand hygiene" as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of the policy entitled Diet Order, Tab 07-06, from the Food Services Manual; dated August 2015, revealed that the diet order was to include the diet type/texture modification, fluid type, and/or supplementation.

A review of the three month medication review, for resident #001, for a specified three month period, revealed that the diet for resident #001 indicated regular. However, the texture modification and fluid type were not identified.

The registered dietitian acknowledged that the three month medication review did not contain the required information. She also confirmed the expectation was that the policy was to be complied with and that the diet order should have included the diet type/texture modification and fluid type. [s. 8. (1) (a),s. 8. (1) (b)]

3. A. A review of the policy entitled Nutrition and Hydration, Tab 07-24, in the Food Services Manual; dated April 2014, indicated the following:
"HYDRATION - page 3
• Each evening, the Nutrition and Hydration Flow Sheets will be tallied by the Night PCA Team, which will included the Daily Additional Fluids Chart. The Night RPN/RN will review and initial the Total Daily Fluid Intake. Any Resident who has a fluid intake less than their estimated fluid requirements will be reported to the oncoming RPN/RN so that interventions can be initiated (Refer to Nutrition Care Plan for fluid requirements.)
• The RPN will assess signs and symptoms of dehydration (as documented in the Dehydration Risk Assessment Tool), ensure the request for Nutrition Consultation (Tab 07-41) has been initiated for the Registered Dietitian (RD) to assess. The Request for Nutrition Consultation is completed when a Resident has a fluid intake of less than 1000 millilitres or per individual fluid requirement as per the Plan of Care for three(3) consecutive days and there is at least one(1) sign or symptom of dehydration present.
• The extra fluids consumed by the Resident will be documented by the RPN/RN at medication pass on the Daily Additional Fluids Chart ".

"DEHYDRATION RISK ASSESSMENT TOOL – page 9
If one of more signs or symptoms of dehydration are present initiate request for nutrition

consultation.
Signs and symptoms of dehydration:
Skin turgor, as evidenced by tenting of skin
Cracked Lips
Dry mucous membranes (eg. Dry or sunken eyes)
Fatigue/weakness/general feeling of lethargy/malaise
Reduced or no urine output
Concentrated urine – dark yellow in colour
Comatose (severe dehydration)".

The policy was not complied with related to hydration and referral, of residents at risk for dehydration, to the registered dietitian.

A review the Extra Hydration records, for an identified neighbourhood, revealed that there was no record completed for any of the residents on the neighbourhood on one specified date. There were nine to fourteen residents with intakes below 1000 millilitres on four other identified days.

Records for other days in the month reviewed could not be located by the Director of Food Services. She confirmed the numbers of residents below 1000 millilitres on four identified days.
She also confirmed that no additional fluids were provided to the residents on these days.

The Director of Food Services indicated that staff were using the wrong form to record when extra fluids were being given and that it was not the form that was in the policy.

She also indicated that she had not received a referral related to residents at risk for dehydration in over six months.

Individual resident Nutrition and Hydration Flow Sheets were reviewed and intakes for two residents were noted as follows:

Resident #001 had fluid intakes below 1000 millilitres for 42 days, 16 days and then another 13 days in a 12 week time frame.

Observations of resident #001 throughout the inspection revealed that the resident was fatigued/weak/and had a general feeling of lethargy.

A review of the clinical record revealed that the dehydration resident assessment protocol, with an identified date, revealed that resident #001 was diagnosed with a urinary tract infection and treated with an antibiotic.

The Director of Food Services confirmed that the clinical record identified that the resident was at high nutritional risk and at risk for dehydration and referrals to the registered dietitian should have been made.

Resident #004 had a fluid intake below 1000 millilitres for four days, six days and then another five days during a 26 day time frame. The intake for the six day period was noted to have intakes as low as 300 millilitres on two days and the average intake was 541 millilitres.
The Director of Food Services reviewed the plan of care, on GoldCare, with Inspector # 128 and it was noted that the resident had a fluid requirement approximately three times that amount for each day.
The Director of Nursing and the Director of Food Services both acknowledged that this resident was high nutritional risk and had been at risk for dehydration since admission over seven months ago.
The Director of Food Services confirmed that the high dehydration risk was on the care plan for this resident and no referrals had been made to the registered dietitian.

The Nutrition and Hydration Flow Sheets were reviewed with the Director of Food Services and it was noted that the fluid intakes for 13 other residents were below 1000 millilitres from four to 26 days, during a 26 day time frame. One resident had a recorded intake that was below 250 millilitres for eight of the days.

The Director of Nursing indicated that the expectation would be that when staff saw intakes as low as 200 and 300 millilitres per day that progress notes should be documented and referrals should be sent to the registered dietitian if intakes were less than 1000 milliltres for three days.

The Director of Nursing and Director of Food Services acknowledged after searching GoldCare that there were zero progress notes related to dehydration for any of the residents on the identified neighbourhood for the month being reviewed.

The Director of Food Services confirmed that 15/32 residents (47%) were at risk for dehydration.

She also acknowledged that registered staff did not assess these residents for signs and symptoms of dehydration, when their intakes were below 1000 millilitres for three days, and did not send referrals to the registered dietitian for consultation.

The Director of Nursing confirmed that the hydration policy was not being followed and acknowledged that this was a high risk issue that needed to be addressed.

The Registered Dietitian confirmed that no referrals had been made related to dehydration for any of the above residents and acknowledged the policy was not being complied with.

B. The policy entitled Nutrition and Hydration, Tab 07-24, in the Food Services Manual; dated April 2014, also indicated on page 4, under the Teacart procedure to "Make note of the amount of fluid and food offered to each Resident; document intake of food and fluid at time of service". The policy contained an addendum that indicated the tea cart glasses contained 200 millilitres fluid.

The policy was not complied with related to the documentation for the evening snack cart, on an identified date, not being completed at the time of service and the fluids provided to residents not being documented in the amounts that were offered to residents for both labelled and unlabelled beverages.

The food and fluid documentation binder was not observed on the snack cart on the identified date.

The labelled glass of juice observed at the evening snack, for resident #001 indicated that it contained a specific number of millilitres.
A personal support worker confirmed the labelled beverage for resident #001.

The next day, Inspector #128 questioned the Assistant Director of Food Services as to how much fluid was contained in the glasses that were being used on the snack cart and in the dining room. The Inspector and the Assistant Director of Food Services measured the volume of fluid that was observed being served in the dining room at the time and on the snack cart, in the identified neighbourhood. It was noted that the glass held 150 - 180 millilitres of fluid and not 200 millilitres of fluid. The Assistant Director of Food Services confirmed this.

A personal support worker confirmed, that day, that the personal support workers were

recording the glass size as 200 millilitres despite the glass not holding this amount.

A review of the nutrition and hydration flow sheets revealed that personal support workers were documenting 200 millilitres of fluid at snack for the last three months.

The registered dietitian acknowledged that the documentation and the amount of fluid in the glass needed to align.

The Director of Food Services acknowledged that the juice being provided to resident #001 could not be the specified number of millilitres on the label because the juice glass would only hold 180 millilitres of fluid without being too full. She acknowledged that the policy was not being followed.
The registered dietitian confirmed that the glasses held a maximum of 180 millilitres without being too full for use by residents.

C. The policy entitled Nutrition and Hydration, Tab 07-24, in the Food Services Manual; dated April 2014 also noted on page 5, that a typical day of fluid indicated that a serving size of water, milk, fruit drink, coffee or tea were 125 millilitres fluid.

The Director of Food Services and registered dietitian acknowledged that the policy was not being followed because the addendum to the hydration policy was being used for fluids which did not match the menu and that the menu indicated that 125 millilitres of fluid was being served.

The Director of Nursing indicated that the expectation was that all policies were complied with.

The severity of the issue was determined to be potential for harm related to dehydration and the scope of the issue was a pattern. The home had a history of multiple related and unrelated non-compliance. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 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 all policies, including the policies related to diet terminology and hand hygiene are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The home has a history of non-compliance related to each resident not receiving two baths per week:

A written notification and a voluntary plan of correction were previously issued May 27, 2015, under Log # 008924-15 and inspection #2015_259520_0016.

A written notification and a voluntary plan of correction were previously issued May 27, 2015, under Log # 008251-15 and inspection #2015_259520_0015.

The licensee has failed to ensure that each resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths.

A review of the personal care observation and monitoring form/flow sheets revealed that resident #001 had received four bed baths, in an eight and a half weeks time frame (76% baths not provided). Seven refusals were documented. Only one reattempt was documented as refused.

The family had expressed concerns in regard to resident #001's left hand smelling/having an odour.

A review of the clinical record revealed that the kinesiologist indicated in the progress notes, on an identified date, that "left hand today presented with very strong odour".

The Director of Nursing indicated that the expectation was that two baths per week were provided to each resident and that the baths needed to be documented on the flow sheets. She indicated that the expectation was that staff were to attempt to provide the bath later the same shift if the bath was refused or offer the bath the following day.

The severity of the issue was potential for harm and the scope of the issue was widespread. The home had a history of related and multiple unrelated non-compliance. [s. 33. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A review of the clinical record for resident #001 revealed the resident had an order for a medication to be given every hour when necessary for agitation. A review of the medication administration record (MAR) for a one month time frame revealed that the resident had received the medication 17 times and the MAR indicated a response was required related to the effectiveness. A response was documented four of the 17 times.

A review of the clinical record also revealed that there were no documented progress notes related to effectiveness of the medication.

A registered practical nurse, on the identified neighbourhood, indicated that registered staff were expected to document the effectiveness of all "when necessary" medications. She confirmed that the effectiveness of the identified medication was not documented on the medication administration record 13 of the 17 times (76.5%) it was administered and that there was no documentation in the progress notes for the missing responses.

The Director of Nursing confirmed that staff were expected to document the effectiveness of medication on the medication administration record.

The severity of the issue was potential for harm and the scope of the issue was widespread. The home did not have a history of non-compliance related to this issue but did have a history of other unrelated non-compliance. [s. 134. (a)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

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 has failed to ensure that residents were offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner as well as a snack in the afternoon and evening.

On an identified date, a personal support worker was observed to enter the room of resident #001 with a glass of juice. When the resident was observed to be sleeping the personal support worker stated "oh he/she is sleeping, I will come back later". No attempt was made to rouse the resident who was noted to be at high nutritional risk and 7.7 kilograms below the identified goal weight in the plan of care.
Later that day, the same personal support worker acknowledged that no further attempts were made to offer resident #001 an afternoon beverage or snack.

During the evening snack observation, initiated at 20:15, on an identified date, it was noted that nine residents were not offered a beverage or a snack. The personal support worker indicated that these residents were sleeping. Two additional residents were offered a beverage but no snack and one resident was offered a snack but no beverage. Of the 19 residents observed 11 were not offered a snack (58%) and 10 were not offered a beverage (53%). Four residents refused a snack and beverage.

The personal support worker serving the evening snack cart indicated that sleeping residents were not provided with a beverage or snack.

The Director of Care indicated the expectation was that each resident should be offered a beverage in the morning, as well as an afternoon and evening snack and beverage. She indicated, however, that it was not the expectation that every resident be wakened

during evening snack. She indicated that the expectation was that the snack cart was to be delivered at 19:00 or 19:30 at the latest to avoid so many residents being asleep.

The severity of the issue was potential for harm and the scope of the issue was a pattern. The home did not have a history of non-compliance related to this issue but did have a history of other unrelated non-compliance. [s. 71. (3)]

2. The licensee has failed to ensure that the planned menu items were offered at each meal.

A review of the planned menu for lunch, on November 24, 2015, indicated that cream of tomato soup, turkey and cranberry sandwich, creamy coleslaw and mixed berries were one of the choices. An alternate choice was also available.
The week at a glance menu plan also indicated that whole wheat bread, margarine, 250 millilitres of water and 250 millilitres of milk along with tea/coffee were offered at all meals.
Observation of the lunch meal offered to resident #001, November 24, 2015, revealed that it did not contain the full menu plan. A sandwich, coleslaw and apple juice were offered to the resident on a tray. No soup, water, milk, tea/coffee or dessert was offered to the resident.
Observation of the supper meal, November 24, 2015, revealed that resident #001 was offered an entrée, vegetable and dessert as per the menu plan. No bread, water, or milk was offered to the resident.
A personal support worker confirmed the contents of the tray.

Observation of the lunch meal tray offered to resident #001, on November 25, 2015, revealed the resident was not offered the soup, water, milk, tea/coffee as per the planned menu.
A personal support worker and a registered practical nurse confirmed the contents of the tray.

The Director of Food Services indicated the expectation was the full menu plan be offered when a tray was being taken to a resident's room and that the soup, bread, milk, water, and tea/coffee on the menu should have been offered to resident #001, as well as dessert. [s. 71. (4)]

Additional Required Actions:

CO # - 007 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 planned menu items are offered at each meal, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods; O. Reg. 79/10, s. 72 (2).
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable; O. Reg. 79/10, s. 72 (2).
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system provided for production sheets for snack menus and that all menu items were prepared according to the planned menu.

Observation of the evening snack, on an identified date, revealed that all of the required items as per the menu were not on the snack cart and/or in the necessary quantities.

The menu indicated that assorted sandwiches, fresh fruit, apple drink, tea, coffee, and milk were on the menu.

The food observed on the snack cart was 17 quarter sandwiches, a bowl of fresh fruit, two unlabelled pureed texture snacks, one labelled pureed texture cookie, one labelled thickened fluid, one labelled apple juice, one labelled fruit cup, and two and a half sandwiches labelled for individual residents. There was also a jug of diet apple drink, coffee, tea and milk on the snack cart. The cart did not contain any regular apple drink.

A personal support worker confirmed the contents of the snack cart and indicated that the sandwiches were not labelled so the type of sandwich was unknown. The PSW also confirmed that neither a diet list nor menu were on the snack cart.

A diet list in the identified neighbourhood servery revealed that there were 26 residents on minced and regular texture diets. The menu indicated that each resident was to receive a half assorted sandwich for evening snack and residents on diabetic and renal diets were to receive low calorie apple drink. The diet list indicated that 24 residents were to receive regular apple drink and the eight residents were to receive the low calorie beverage. The diet list also indicated that there were seven residents on thickened fluids.

The Director of Food Services acknowledged that the home did not have production sheets to guide the quantities required for food production and items to be prepared for snacks. She indicated that a diet census count sheet was used to determine what should be on the snack cart. She confirmed that there should have been the equivalent of 13 full sandwiches/26 half sandwiches on the evening snack cart. She confirmed that the labelled sandwiches along with the 17 quarter sandwiches provided were inadequate in quantity. This was 52 per cent of the required amount. The Director of Food Services confirmed that there were five residents on a pureed texture and that the three pureed snacks would have been an inadequate quantity. She also confirmed that the personal support workers were responsible for making the thickened fluids using a thickening agent and the thickener should have been available on the snack cart to ensure residents requiring thickened fluids received them.

A review of the undated diet census count sheet revealed that it indicated that there were four residents on thickened fluids but it did not coincide with the diet list which indicated that seven residents required thickened fluids.
The Director of Food Services acknowledged that the numbers on the diet census count sheet were incorrect as seven residents required thickened fluids.

The Director of Food Services indicated that production sheets were required to ensure adequate quantities of food were prepared and that all menu items need to be prepared according to the planned menu.

The severity of the issue was potential for harm and the scope of the issue was a pattern with the potential to affect the whole home. The home did not have a history of non-compliance related to this issue but did have a history of other unrelated non-compliance. [s. 72. (2)]

Additional Required Actions:

CO # - 008 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 the food production system, at a minimum, provides for preparation of all menu items according to the planned menu, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration programs included the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration.

There was no documented evidence to support that as part of the dietary services/dining and snack service, the home had a policy related to ensuring that proper techniques were used to assist residents with eating/drinking, including safe positioning of residents who required assistance.

During an interview, the Director of Nursing indicated that the home did not have a policy related to proper techniques to assist residents with eating, including safe positioning and that the home did not do training on this because staff should know this as they are taught this in school.

Inspector #128 indicated to the home that three instances of unsafe positioning, while assisting residents' with eating, had been observed the previous day. Two of the instances were in regard to resident #001. This resident was noted to be at high nutritional risk and had documentation in the clinical record written, on an identified date, by the physician indicating that the resident needed to be upright while being assisted with eating/drinking.

The Director of Food Services also confirmed that the home did not have a dietary policy related to safe eating and acknowledged this was a requirement in the legislation and that the home should have a policy as part of the dietary services program.

The severity of the issue was potential for harm and the scope of the issue was widespread as it potentially affects all residents requiring assistance with eating/drinking. The home did not have a history of non-compliance related to this issue but did have a history of other unrelated non-compliance. [s. 68. (2) (a)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received individualized personal care, including hygiene care and grooming on a daily basis.

At approximately 11:50, on an identified date, a registered practical nurse was observed administering medications with water to resident #001. The resident was in bed and had been rolled up to approximately a 140 degree angle. The glass of water spilled on the resident when the resident's hand hit the glass. The registered practical nurse offered to change resident's night attire but the resident refused. The registered practical nurse rolled a washcloth and tucked it into the resident's undershirt/night wear to absorb the spilled water.

In the evening, the same day, it was observed that resident #001's daughter washed all of the clothes in the laundry hamper for the resident. The daughter confirmed that the family provided the wash cloths for the resident and did all the resident's laundry.

The next day, at 17:45, another registered practical nurse was administering medications to resident #001 who was eating supper in bed. The registered practical nurse asked the resident why the wash cloth was stuck in his/her undershirt. The resident responded "I don't know".

Observations at the same time, revealed that there were no dirty clothes or wash cloths in the laundry hamper and that resident #001 was in the same night attire as the day before.

At approximately 18:00, the same day, the personal care observation and monitoring form/flow sheet for resident #001 was reviewed and it was noted that it was documented that the resident required total assistance to be dressed by one staff member on the day shift that day. The form also indicated that personal hygiene care had been provided on the day shift requiring the total assistance of two staff.

A review of the same records, in the early afternoon the next day, revealed that they had been changed and they indicated that resident #001 refused to be dressed on the day shift, the previous day.

A personal support worker acknowledged that the resident had not been changed on day shift on the day in question.

During an interview, a registered practical nurse confirmed that he/she had spilled water on resident #001 during medication administration and had rolled up a washcloth which was inserted into the resident's undershirt/night wear to soak up the water. The registered practical nurse indicated that it was reported to the oncoming shift that the water had been spilled on the resident and the oncoming shift was requested to monitor the washcloth in the undershirt/night wear. The RPN indicated that the expectation was that the resident should have received daily hygiene care and had his/her clothing changed.

The Director of Nursing acknowledged that the expectation was that each resident was groomed daily. She indicated that personal care needed to be provided as well as the re-attempts to provide care were expected to be documented on the flow sheets. [s. 32.]

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 each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

Observations in the washroom of resident #001, on identified date, at 11:38, revealed that the resident's bottom denture was in a denture cup and that the toothbrush and denture brush, as well as the two drinking glasses were dry.

Two personal support workers indicated that the resident had been sleeping all morning.

A review of the personal care observation and monitoring form/flow sheets for that day indicated that oral care had been provided in the morning but there was nothing documented for the evening or night shift.

A review of the personal care observation and monitoring form/flow sheets, indicated that resident #001 had received oral/mouth care 32 times in a 60 day period. The records identified that there were 37 days that the resident did not receive any oral care. Fifty seven refusals were documented.

The Director of Nursing indicated the expectation was that oral care was provided twice daily and re-attempts needed to be documented on the flow sheets. She indicated that the expectation was that staff re-approach resident #001, using a different staff member and attempts could be made on day, evening and night shifts. [s. 34. (1) (a)]

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 each resident receives oral care to maintain the integrity of the oral tissue, that includes mouth care in the morning and evening, and/or cleaning of dentures, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received assistance to use personal aids.

Resident #001 was observed eating supper in bed, on an identified date, at 17:43. A personal support worker was assisting the resident with eating. At approximately 17:44, the resident's family member arrived and said "you don't have your specs on" and placed the resident's glasses on his/her face. Resident #001 was speaking to the inspector and the family member indicated that the resident probably couldn't hear the inspector because the resident's hearing aide hadn't been inserted.
At 18:43, while Inspector #128 was speaking to the resident it was observed that the resident did not have his/her bottom dentures in place. The resident's family member commented that it wasn't much wonder the resident didn't eat his/her supper.

The next day, at 16:04, resident #001's glasses and hearing aide were observed sitting on the bedside table.
At 17:45, the same day a registered practical nurse was observed administering medications to resident #001 who was in bed at the time. The resident spoke to Inspector #128 but indicated that he/she couldn't hear the inspector. The resident's hearing aide was observed sitting on the bedside table. The registered practical nurse acknowledged that the hearing aide had not been inserted and that it should have been.

The General Manager acknowledged during an interview that the resident should have been receiving the care and assistance that was required to use personal aids. [s. 37. (2)]

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 each resident receives assistance, if required, to use personal aids, to be implemented voluntarily.

WN #11: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating/drinking, including safe positioning of residents who required assistance.

At approximately 11:50, on an identified date, a registered practical nurse was observed administering medications with water to resident #001. The resident was in bed in a horizontal position and had been rolled up to a reclined position, at approximately a 140 degree angle. Inspector #128 questioned if the resident was in a safe position for drinking and the registered practical nurse indicated that the resident would not allow staff to roll him/her up any further. Inspector #128 was present and noted that the resident did not refuse to be rolled up higher. The glass of water spilled on the resident when the resident's hand hit the glass.

Medication administration was also observed for resident #001, the same day, at 17:34. The resident was still in bed and was reclined, at approximately a 130 degree angle. The resident was not repositioned until after Inspector #128 asked the registered practical nurse who was administering the medication about safety related to the resident consuming resource and medications while in that position. The registered practical nurse indicated that he/she thought the resident was between a 45 and 60 degree angle i.e. 120 – 135 degrees. The registered practical nurse indicated that the resident wasn't repositioned because the resident slid down as fast as they put him/her up but the registered practical nurse did reposition the resident with a personal support worker. The resident was noted to stay in the same upright position until after 18:00.

A review of resident #001 hard copy multidisciplinary progress notes, written by the resident's physician, on an identified date, indicated that an assessment related to swallowing was not being made to a speech language pathologist (SLP) related to a quality of life choice. However, the note indicated that a SLP would suggest "positioning upright" and that "this should be done".

During the evening snack, the same day, resident #003 was observed being assisted with drinking while reclined in bed, at approximately a 130 degree angle. Inspector #128 asked the personal support worker if the resident was safely positioned and the personal support worker rolled the bed a little higher and acknowledged that the resident should have been in a higher position.

The General Manager indicated that the expectation was that residents were to be as upright as possible when drinking/eating and positioned so that each resident didn't slide. She indicated that staff should be seated to assist residents and if the resident required a straw or a lid on their beverage then the lid should be on the drink. She indicated that if the resident was in bed then 45 degrees was too low i.e. 135 degrees was too low.

The Registered Dietitian indicated during an interview that residents were expected to be positioned upright and as close to a 90 degree angle as possible while being assisted with eating/drinking. She noted that to ensure proper techniques were used to assist residents with eating/drinking that staff should be at eye level with the resident and indicated that when a resident was lying in bed, being reclined as low as 130 degrees was "not okay" in terms of safe positioning. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that proper techniques are used to assist residents with eating/drinking, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented complaint record was kept in the home that included:
- time frames for actions to be taken to resolve complaints and any follow-up action required;
-the final resolution, if any;
-every date on which any response was provided to the complainant and a description of the response; and
- any response made by the complainant.

A review of the home's complaint/concern binder, on November 30, 2015, revealed a Resident/Family Concerns Response Form had been filled out for resident #001, on an identified date. The concerns/complaints lodged by a family member were related to health and medications of the resident.
The form did not contain any documentation to support time frames for actions to be taken and whether there was a final resolution. The issues were noted to be ongoing. Additionally, the form did not contain every date on which any response was provided to the complainant and a description of the response nor whether the complainant made any responses.

The General Manager confirmed during an interview, on December 1, 2015, that the family/resident concern form did not include all of the items that were required to be kept on the documented complaint record in the home. [s. 101. (2)]

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 a documented complaint record is kept in the home that includes:
- time frames for actions to be taken to resolve complaints and any follow-up action required;
-the final resolution, if any;
-every date on which any response was provided to the complainant and a description of the response; and
- any response made by the complainant, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A review of the physician's orders, in the hard copy clinical record for resident #001, revealed that resident #001 had an order, to discontinue a medication at 2000, and to (give) a different medication at 2100 instead.

A review of the medication administration record revealed that the new medication was not administered to resident #001 for three days.
The order for the new medication was discontinued, on the physician's orders, on the fourth day.

The Director of Nursing confirmed during an interview that the new order was never processed. She indicated it was not put on the medication administration record and that it was not discontinued until four days later. She acknowledged that this was a medication incident and that the expectation was that drugs were administered to each resident as prescribed. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received fingernail care, including the cutting of fingernails.

Observations of resident #001, at 19:29, on an identified date, revealed that the fingernails on the resident's right hand were long and untrimmed. They were also noted to have black debris under the fingernails. The resident's family member confirmed the observation and informed Inspector #128 that he/she had trimmed the fingernails on the resident's left hand recently.

Two days later, at 10:00, a personal support worker confirmed the observation that the fingernails were not clean and indicated that they definitely needed to be trimmed, as well.

The Director of Care acknowledged that the expectation was that each resident was groomed including fingernail care. [s. 35. (2)]

Issued on this 31st day of December, 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUTH HILDEBRAND (128)
Inspection No. / No de l'inspection :	2015_183128_0023
Log No. / Registre no:	031635-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 18, 2015
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF GLENDALE CROSSING 3030 Singleton Avenue, LONDON, ON, N6L-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHELLE VERMEEREN

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, implement and submit a plan for achieving compliance with LTCHA, 2007 S.O. 2007,c.8, s.6 (7) to ensure that the plan of care is provided to each resident as specified in the plan.

The plan must identify when and how staff will be provided education to ensure that care is provided to resident #001 and all other residents as specified in their plans of care.

The plan must identify who will be responsible for monitoring the care provided to resident #001 including but not limited to the following:
-ensuring that pain assessments are completed;
-ensuring that supplements are provided to the resident as ordered; and
-ensuring that the resident is supported to be provided with recreational activities he/she desires and one to one visits.

The plan must identify who will be responsible for monitoring the care provided to other residents.

The plan must identify who will be responsible for completing the identified tasks and monitoring the documentation on an ongoing basis.
Please identify the time frames when each of the components will be achieved.

Please submit the written plan to Ruth Hildebrand, Long-Term Care Homes Inspector - Dietary, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 130 Dufferin Ave, 4th Floor, London, ON N6A 5R2, via email by December 30, 2015.

Grounds / Motifs :

1. The home has a history of non-compliance with plans of care not being provided:

A written notification and a voluntary plan of correction were previously issued May 27, 2015, under Log # 008040-15 and inspection #2015_259520_0017.

A written notification and a voluntary plan of correction were previously issued August 1, 2013 under Log # L-000584-13 and #L-000531-13 and inspection #2013_229213_0022.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan in regard to pain assessments, orders for supplements and the recreation plan of care.

A. A review of the medication administration record (MAR), for resident #001, revealed the resident was to have a weekly pain assessment. It indicated "assess pain, attach vital and document in pain binder".

A review of the pain binder revealed that there was no evidence to support that any weekly pain assessments had been completed in an identified four month time frame.

A review of resident #001's hard copy chart also revealed no evidence to support that any pain assessments had been completed during the four months.

Medication administration records were reviewed for the identified four months. During that 17 week period it was noted that six pain assessments had been completed on the medication administration record.

A registered practical nurse, on the identified neighbourhood confirmed that 11/17 (65%) pain assessments had not been completed on the medication administration record. The registered practical nurse also confirmed that there were no pain assessments in the hard copy clinical record for the resident and that there were no pain assessments in the pain binder in that four month time frame.

The Director of Nursing indicated that the expectation was that the resident's plan of care should have been followed and if the resident was to have pain assessments completed weekly, with documentation in the pain binder, then that was what should have happened.

B. A review of the three month medication review, for resident #001, during an identified three month time frame, revealed an order for a supplement three times per day at three specific times with med pass.

The clinical record revealed that the resident was at high nutritional risk and was 7.7 kilograms below the identified goal weight range.

On an identified date, resident #001 was observed in bed in his/her room. A registered practical nurse was observed attempting to give the resident his/her medications. The resident indicated that he/she did not wish to take the medication. The supplement was left sitting on the table beside the resident's lunch.

One hour and 23 minutes later, resident #001 was observed in bed asleep and the supplement was observed sitting untouched on the table.

At the next meal, a registered practical nurse was observed administering a supplement to resident #001 who was in bed at the time. Inspector #128 asked the registered practical nurse what he/she had done with the other supplement from lunch. He/she indicated that he/she had thrown it out and confirmed that the previous supplement was not provided to the resident.

A review of the medication administration record, for resident #001, the next day, revealed that the supplement from the previous day was signed as being given to the resident 21 minutes after it was refused by the resident and subsequently thrown out.

A registered practical nurse was questioned about the amount of supplement being given to resident #001. The registered practical nurse indicated that 90 millilitres of supplement was being provided and indicated that registered staff always gave the supplement in the dixie cup being used.

Inspector #128 measured the equivalent amount of water in the dixie cup and determined that approximately 70 millilitres was the amount of supplement being

given. The registered practical nurse confirmed that only 70 millilitres was being provided to the resident. The registered practical nurse indicated that the dixie cup glass only held 90 millilitres so they couldn't fill it to the brim or it would spill on the resident. The registered practical nurse confirmed that the supplement was not being provided as per the plan of care and acknowledged that it was routinely signed for as 90 millilitres of supplement not the actual 70 millilitres.

The registered dietitian indicated, during an interview, that she had written the order for the supplement to be given to the resident and the expectation was that the plan of care was followed. She indicated that if 90 millilitres didn't fit in the dixie cups used to dispense the supplement then her expectation was that a larger glass would be used.

C. A review of the three month medication review, for resident #001, for a specified three month period revealed an order for a supplement, one package three times per day in juice.

The clinical record revealed that the resident was at high nutritional risk and was 7.7 kilograms below the identified goal weight range.

Observations of resident #001, on an identified date, revealed that the resident did not have juice with the supplement in it prior to the supper meal.

A personal support worker confirmed, at 11:50 that day, that the resident had only had two sips of regular juice all morning.

Observation of the noon meal tray revealed that there was no supplement in the juice. Three personal support workers confirmed, at 13:50, that they had not given any supplement to the resident that day. One of the personal support workers indicated that the registered staff usually gave the personal support workers the supplement to put in the juice.

A fourth personal support worker confirmed at 16:12, that resident #001 did not have an afternoon beverage or snack.

A review of the medication administration record, for resident #001, the next day, revealed that the supplement was signed as being given to the resident at 13:26, the previous day.

The registered dietitian indicated, during an interview, that she had written the order for the supplement to be given to the resident and the expectation was that the plan of care was provided.

D. A review of the plan of care for resident #001, revealed that the care plan indicated that resident #001 would like a one to one visit more than a group program. The care plan goal indicated "provide a one to one visit a week". The care plan also indicated that the resident would participate in other group programs occasionally.

A review of the multi-month participation report revealed that resident #001 had attended three activities, including two one to one visits, in one identified month. Zero activities were attended in the next month and four activities, with no one to one visits were attended the following month.

A Recreation Coordinator acknowledged that she/he tried to do two or three one to one visits, per month with resident #001 but they were not always documented. She/he indicated that one to one visits were not always completed if resident #001 attended a group activity instead. The Recreation Coordinator acknowledged that the documentation reflected that there were three activities in the identified month, zero activities in the next month and four activities in the following, with two one to one visits in the three month period.

The General Manager indicated that the expectation was that the care set out in the plan of care for each resident was provided to the resident as specified in the plan of care, including the personal recreation and well-being plan of care.

The severity of the plan of care not being provided was determined to be potential for harm as the resident is at high nutritional risk. The scope of the issue was a pattern. The home had a history of related and multiple unrelated non-compliance. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must ensure compliance with LTCHA, 2007 S.O. 2007, c. 8, s. 6 (1) by reviewing and revising the plan of care for resident #001 to ensure it provides clear direction to all staff who provide direct care to the resident.

The revisions to the plan of care must include but not be limited to:
- the amount of personal assistance and encouragement the resident is to receive to eat and drink as comfortably as possible;
- the correct diet;
- dressing;
- direction in terms of safety devices required, personal assistance required and ability to walk and
-the amount of fluid to be provided at meals and snacks.

After the plan of care is revised and provides clear direction, direct care staff must be made aware of the changes.
The home must document the education provided to direct care staff related to the updated plan of care.

The home must also develop and implement a mechanism to ensure that direct care staff are aware of updates to plans of care for residents each time they are reviewed and revised.

Grounds / Motifs :

1. 1. The home has a history of non-compliance with plans of care not providing

clear direction:

A written notification and a voluntary plan of correction were previously issued September 15, 2015, under Log # 024284-15 and inspection #2015_217137_0040.

A written notification and a voluntary plan of correction were previously issued October 2, 2014 under Log # 004625-14 and inspection #2014_303563_0037.

A written notification and a voluntary plan of correction were previously issued February 5, 2013 under Log # L-00077-13 and 2013_186171_0005.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A. A review of the plan of care revealed that it did not provide clear direction in terms of the amount of personal assistance and encouragement resident #001 required to safely eat and drink as comfortably and independently as possible.

The clinical record revealed that the resident was at high nutritional risk and was 7.7 kilograms below the identified goal weight range.

The personal care profile, located in the dietary binder in a servery, was reviewed and it was noted that it indicated that resident #001 required "total assistance with eating/feed all meal". The profile had an identified date.

A personal support worker questioned Inspector #128, on an identified date, in regard to whether staff had to stay with resident #001 while the resident was eating if family was present. The personal support worker indicated that staff found it difficult to stay with resident #001 when meal service was happening in the dining room.

A registered practical nurse questioned Inspector #128, the next day, in regard to whether the staff were required to stay with the resident throughout each meal. The registered practical nurse indicated that one family member indicated that he/she did not want to assume responsibility while the resident was eating.

A review of the activities of daily living functional rehab potential/restorative care

plan resident assessment protocol(RAP), with an identified date, indicated that staff were to stay with resident #001 when the resident ate for safety.

The care plan developed by the registered dietitian indicated that resident #001 was to be provided cueing to complete meals.

The activities of daily living care plan, indicated under eating/dehydration that resident #001 required "++ motivation to eat".

The personal expressions care plan indicated interventions for resident #001 if resident did not come for lunch or displayed responsive behaviours.

The Director of Nursing indicated in an interview that staff had been given direction that they were to stay with resident #001 at all times throughout the meal, unless the family wanted to assume care for the resident during the meal.

The Director of Food Services indicated that resident #001 did not require total assistance with eating or to be fed all meals. She indicated that the plan of care should be consistent and provide clear direction to staff.

B. A review of the plan of care revealed that it did not provide clear direction in terms of the diet that resident #001 was to receive.

A review of the clinical record revealed that the activities of daily living functional rehab potential/restorative care plan RAP, with an identified date, indicated that resident #001's current diet order was regular diet, minced texture, thickened fluids.

It was noted that the diet list in a neighbourhood servery and the high nutritional risk care plan in the clinical record indicated that the resident was on a regular/regular/regular diet.

The activities of daily living care plan indicated under eating/dehydration that resident #001 was on a minced texture, regular fluids(sips), regular diet.

The registered dietitian indicated during an interview that there should only be reference to one diet in the plan of care and confirmed that the plan of care should provide clear direction to staff.

C. A review of the plan of care revealed that it did not provide clear direction, for resident #001, in terms of bathing.

The activities of daily living care plan indicated that resident #001 was to receive a bed bath twice a week, on specified days.

An identified neighbourhood bathing schedule indicated that resident #001 was to be bathed on the evening shift on different days.
The personal care plan also used by the personal support workers to provide care indicated that the resident was to be bathed on the day shift on the days specified in the activities of daily living care plan.

A personal support worker confirmed that the plan of care did not provide clear direction related to bathing. The personal support worker indicated that staff have not been able to bathe resident #001 on day shift "in a long time".

The Director of Nursing confirmed that the expectation was that the plan of care provided clear direction to staff and that it should be consistent throughout the plan of care.

D. A review of the plan of care, for resident #001, revealed that it did not provide clear direction in terms of dressing.

The plan of care for resident #001 revealed that the activities of daily living functional rehabilitation/restorative care plan RAP, with a specified date, identified that staff needed to assist resident #001 with dressing. It noted resident was able to assist with dressing on occasion. He/she did require assistance with putting on his/her pants and socks, doing up buttons and zippers.

The activities of daily living care plan indicated that resident #001 required total assistance with dressing. Staff were required to put on pants and shoes. The resident was able to assist with the shirt by putting arms through sleeves, however would frequently opt not to help.

During an interview two personal support workers indicated that resident #001 had not been dressed for approximately five months as the resident wore night clothes. A registered practical nurse present for the interview also confirmed that it had been at least five months since the resident had been fully dressed

because the resident's shoulder was too painful to get dressed.

The Director of Nursing confirmed that the expectation was that the plan of care provided clear direction to staff and that it should be consistent throughout the plan of care.

E. A review of the plan of care, for resident #001, revealed that it did not provide clear direction in terms of safety devices required, personal assistance required for transferring and ability to walk.

The activities of daily living care plan, with an identified date, indicated in the transferring and falls prevention sections that resident #001 was to have safety measures in place as the resident "will forget to call for assistance with transferring". It also indicated that the resident required the use of an assistive device for all transfers.

A personal support worker confirmed that the plan of care did not provide clear direction related to safety devices. The personal support worker indicated that neither of the safety devices identified were used for resident #001.

The personal care plan used by the personal support workers to provide care indicated that the resident's transfer status was one person assist (limited), ensure safety device was active, and the resident walked with a walker.

The resident was observed either in bed or in a wheelchair throughout the inspection.

Two personal support workers were observed transferring resident #001 with an assistive device, on an identified date and indicated that the resident needed to be transferred using an assistive device.

The kinesiologist indicated in an interview that resident #001 was no longer able to walk and used a wheelchair.

The Director of Nursing confirmed that the expectation was that the plan of care provided clear direction to staff and that it should be consistent throughout the plan of care.

F. A review of the plan of care revealed that it did not provide clear direction in

terms of the amount of fluid resident #001 was to be provided.

The high nutritional risk care plan revealed that the resident was to be provided and encouraged an identified amount of fluids at snacks.

The personal care profile, located in the dietary binder in an identified servery, was reviewed and it was noted that it indicated that resident #001 was to be provided an identified beverage in a specific quantity at each snack and that at afternoon snack the resident was to receive two of the identified beverages.

The diet list that was to be used on the snack cart indicated the identified beverage for the afternoon snack but the quantity was not specified.

On an identified date, a personal support worker was observed with one of the identified beverages for resident #001. The resident was sleeping so was not provided with any beverages at the afternoon snack that day.

The Director of Nursing confirmed that the expectation was that the plan of care provided clear direction to staff and that it should be consistent throughout the plan of care.

The severity of the plan of care not providing clear direction was determined to be potential for harm and the scope of the issue was isolated to one resident with six areas of the plan of care not providing clear direction. The home had a history of related and multiple unrelated non-compliance. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure that O. Reg. 79/10, s. 8 (1) (b) is complied with in regard to the home's the Nutrition and Hydration policy being complied with.

The plan must include but not be limited to the following:

-immediate steps to be taken to monitor the hydration status of resident #001, as well as all other residents identified at dehydration risk and identify how interventions to prevent dehydration will be implemented;
-education of all direct care staff related to the hydration policy including expectations that the registered staff monitor the documentation on the food and fluid flow sheets for all residents to ensure referrals are made to the registered dietitian when required.

Education must also be provided to direct care staff related to amounts of fluid to be documented, after the home has reviewed the menu and determined that the menu, hydration policy and glass sizes align.

The plan must identify who will be responsible for completing the identified tasks and time frames when each of the components will be achieved.

Please submit the written plan to Ruth Hildebrand, Long-Term Care Homes Inspector - Dietary, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 130 Dufferin Ave, 4th Floor, London, ON N6A 5R2, via email by December 30, 2015.

Grounds / Motifs :

1. The home has a history of non-compliance with policies not being complied with:

A written notification and a voluntary plan of correction were previously issued October 6, 2015, under Log # 024636-15, #024664-15, and # 027147-15 and inspection #2015_262523_0027.

A written notification and a voluntary plan of correction were previously issued October 6, 2015, under Log # 027142-15 and inspection #2015_262523_0026.

A written notification and a compliance order were previously issued September 15, 2015, under Log # 024284-15 and inspection #2015_217137_0040.

A written notification and a voluntary plan of correction were previously issued December 18, 2014 under Log # 009192-14 and inspection #2014_263524_0044.

A written notification and a voluntary plan of correction were previously issued November 24, 2014 under Log # L-001536-14 and inspection #2014_216144_0063.

A written notification was previously issued August 1, 2013 under Log # L-000584-13 and #L-000531-13 and inspection #2013_229213_0022.

A written notification and a voluntary plan of correction were previously issued July 2, 2013 under Log #L-000333-13 and inspection #2013_183135_0027.

The licensee has failed to ensure that policies related to nutrition and hydration were complied with.

A. A review of the policy entitled Nutrition and Hydration, Tab 07-24, in the Food Services Manual; dated April 2014, indicated the following:
"HYDRATION - page 3
• Each evening, the Nutrition and Hydration Flow Sheets will be tallied by the Night PCA Team, which will included the Daily Additional Fluids Chart. The Night RPN/RN will review and initial the Total Daily Fluid Intake. Any Resident who has a fluid intake less than their estimated fluid requirements will be reported to the oncoming RPN/RN so that interventions can be initiated (Refer to Nutrition Care Plan for fluid requirements.)
• The RPN will assess signs and symptoms of dehydration (as documented in the Dehydration Risk Assessment Tool), ensure the request for Nutrition Consultation (Tab 07-41) has been initiated for the Registered Dietitian (RD) to assess. The Request for Nutrition Consultation is completed when a Resident has a fluid intake of less than 1000 millilitres or per individual fluid requirement as per the Plan of Care for three(3) consecutive days and there is at least one(1) sign or symptom of dehydration present.
• The extra fluids consumed by the Resident will be documented by the RPN/RN at medication pass on the Daily Additional Fluids Chart ".

"DEHYDRATION RISK ASSESSMENT TOOL – page 9

If one of more signs or symptoms of dehydration are present initiate request for nutrition consultation.
Signs and symptoms of dehydration:
Skin turgor, as evidenced by tenting of skin
Cracked Lips
Dry mucous membranes (eg. Dry or sunken eyes)
Fatigue/weakness/general feeling of lethargy/malaise
Reduced or no urine output
Concentrated urine – dark yellow in colour
Comatose (severe dehydration)".

The policy was not complied with related to hydration and referral, of residents at risk for dehydration, to the registered dietitian.

A review the Extra Hydration records, for an identified neighbourhood, revealed that there was no record completed for any of the residents on the neighbourhood on one specified date. There were nine to fourteen residents with intakes below 1000 millilitres on four other identified days.

Records for other days in the month reviewed could not be located by the Director of Food Services. She confirmed the numbers of residents below 1000 millilitres on four identified days.
She also confirmed that no additional fluids were provided to the residents on these days.

The Director of Food Services indicated that staff were using the wrong form to record when extra fluids were being given and that it was not the form that was in the policy.

She also indicated that she had not received a referral related to residents at risk for dehydration in over six months.

Individual resident Nutrition and Hydration Flow Sheets were reviewed and intakes for two residents were noted as follows:

Resident #001 had fluid intakes below 1000 millilitres for 42 days, 16 days and then another 13 days in a 12 week time frame.

Observations of resident #001 throughout the inspection revealed that the

resident was fatigued/weak/and had a general feeling of lethargy.

A review of the clinical record revealed that the dehydration resident assessment protocol, with an identified date, revealed that resident #001 was diagnosed with a urinary tract infection and treated with an antibiotic.

The Director of Food Services confirmed that the clinical record identified that the resident was at high nutritional risk and at risk for dehydration and referrals to the registered dietitian should have been made.

Resident #004 had a fluid intake below 1000 millilitres for four days, six days and then another five days during a 26 day time frame. The intake for the six day period was noted to have intakes as low as 300 millilitres on two days and the average intake was 541 millilitres.
The Director of Food Services reviewed the plan of care, on GoldCare, with Inspector # 128 and it was noted that the resident had a fluid requirement approximately three times that amount for each day.
The Director of Nursing and the Director of Food Services both acknowledged that this resident was high nutritional risk and had been at risk for dehydration since admission over seven months ago.
The Director of Food Services confirmed that the high dehydration risk was on the care plan for this resident and no referrals had been made to the registered dietitian.

The Nutrition and Hydration Flow Sheets were reviewed with the Director of Food Services and it was noted that the fluid intakes for 13 other residents were below 1000 millilitres from four to 26 days, during a 26 day time frame. One resident had a recorded intake that was below 250 millilitres for eight of the days.

The Director of Nursing indicated that the expectation would be that when staff saw intakes as low as 200 and 300 millilitres per day that progress notes should be documented and referrals should be sent to the registered dietitian if intakes were less than 1000 milliltres for three days.

The Director of Nursing and Director of Food Services acknowledged after searching GoldCare that there were zero progress notes related to dehydration for any of the residents on the identified neighbourhood for the month being reviewed.

The Director of Food Services confirmed that 15/32 residents (47%) were at risk for dehydration.
She also acknowledged that registered staff did not assess these residents for signs and symptoms of dehydration, when their intakes were below 1000 millilitres for three days, and did not send referrals to the registered dietitian for consultation.

The Director of Nursing confirmed that the hydration policy was not being followed and acknowledged that this was a high risk issue that needed to be addressed.

The Registered Dietitian confirmed that no referrals had been made related to dehydration for any of the above residents and acknowledged the policy was not being complied with.

B. The policy entitled Nutrition and Hydration, Tab 07-24, in the Food Services Manual; dated April 2014, also indicated on page 4, under the Teacart procedure to "Make note of the amount of fluid and food offered to each Resident; document intake of food and fluid at time of service". The policy contained an addendum that indicated the tea cart glasses contained 200 millilitres fluid.

The policy was not complied with related to the documentation for the evening snack cart, on an identified date, not being completed at the time of service and the fluids provided to residents not being documented in the amounts that were offered to residents for both labelled and unlabelled beverages.

The food and fluid documentation binder was not observed on the snack cart on the identified date.

The labelled glass of juice observed at the evening snack, for resident #001 indicated that it contained a specific number of millilitres.
A personal support worker confirmed the labelled beverage for resident #001.

The next day, Inspector #128 questioned the Assistant Director of Food Services as to how much fluid was contained in the glasses that were being used on the snack cart and in the dining room. The Inspector and the Assistant Director of Food Services measured the volume of fluid that was observed being

served in the dining room at the time and on the snack cart, in the identified neighbourhood. It was noted that the glass held 150 - 180 millilitres of fluid and not 200 millilitres of fluid. The Assistant Director of Food Services confirmed this.

A personal support worker confirmed, that day, that the personal support workers were recording the glass size as 200 millilitres despite the glass not holding this amount.

A review of the nutrition and hydration flow sheets revealed that personal support workers were documenting 200 millilitres of fluid at snack for the last three months.

The registered dietitian acknowledged that the documentation and the amount of fluid in the glass needed to align.

The Director of Food Services acknowledged that the juice being provided to resident #001 could not be the specified number of millilitres on the label because the juice glass would only hold 180 millilitres of fluid without being too full. She acknowledged that the policy was not being followed.
The registered dietitian confirmed that the glasses held a maximum of 180 millilitres without being too full for use by residents.

C. The policy entitled Nutrition and Hydration, Tab 07-24, in the Food Services Manual; dated April 2014 also noted on page 5, that a typical day of fluid indicated that a serving size of water, milk, fruit drink, coffee or tea were 125 millilitres fluid.

The Director of Food Services and registered dietitian acknowledged that the policy was not being followed because the addendum to the hydration policy was being used for fluids which did not match the menu and that the menu indicated that 125 millilitres of fluid was being served.

The Director of Nursing indicated that the expectation was that all policies were complied with.

The severity of the issue was determined to be potential for harm related to dehydration and the scope of the issue was a pattern. The home had a history of multiple related and unrelated non-compliance. (128)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2016

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must ensure compliance with O. Reg. 79/10, s. 33 (1) by ensuring that all residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths.

The licensee must also initiate a monitoring system to ensure when resident #001 is not bathed, the resident is offered a bath at an alternate time.

The monitoring system must be documented including the name(s) of the person (s) responsible for it.

Grounds / Motifs :

1. The home has a history of non-compliance related to each resident not receiving two baths per week:

A written notification and a voluntary plan of correction were previously issued May 27, 2015, under Log # 008924-15 and inspection #2015_259520_0016.

A written notification and a voluntary plan of correction were previously issued May 27, 2015, under Log # 008251-15 and inspection #2015_259520_0015.

The licensee has failed to ensure that each resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths.

A review of the personal care observation and monitoring form/flow sheets revealed that resident #001 had received four bed baths, in an eight and a half weeks time frame (76% baths not provided). Seven refusals were documented. Only one reattempt was documented as refused.

The family had expressed concerns in regard to resident #001's left hand smelling/having an odour.

A review of the clinical record revealed that the kinesiologist indicated in the progress notes, on an identified date, that "left hand today presented with very strong odour".

The Director of Nursing indicated that the expectation was that two baths per week were provided to each resident and that the baths needed to be documented on the flow sheets. She indicated that the expectation was that staff were to attempt to provide the bath later the same shift if the bath was refused or offer the bath the following day.

The severity of the issue was potential for harm and the scope of the issue was widespread. The home had a history of related and multiple unrelated non-compliance. (128)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2015

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 : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure compliance with O. Reg. 79/10, s. 134 to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs.

The plan must include but not be limited to the following:

-education of all registered staff related to documentation of effectiveness of medications;
-identification of who will be responsible for monitoring that registered staff are documenting the effectiveness of medications provided to resident #001; and
-identification of a monitoring system to ensure that the effectiveness of medications is documented for all residents in the home.

Please identify who will be responsible for completing the identified tasks and time frames when each of the components will be achieved.

Please submit the written plan to Ruth Hildebrand, Long-Term Care Homes Inspector - Dietary, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 130 Dufferin Ave, 4th Floor, London, ON N6A 5R2, via email by December 30, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A review of the clinical record for resident #001 revealed the resident had an order for a medication to be given every hour when necessary for agitation. A review of the medication administration record (MAR) for a one month time frame revealed that the resident had received the medication 17 times and the MAR indicated a response was required related to the effectiveness. A response was documented four of the 17 times.
A review of the clinical record also revealed that there were no documented progress notes related to effectiveness of the medication.

A registered practical nurse, on the identified neighbourhood, indicated that registered staff were expected to document the effectiveness of all "when necessary" medications. She confirmed that the effectiveness of the identified medication was not documented on the medication administration record 13 of the 17 times (76.5%) it was administered and that there was no documentation in the progress notes for the missing responses.

The Director of Nursing confirmed that staff were expected to document the effectiveness of medication on the medication administration record.

The severity of the issue was potential for harm and the scope of the issue was widespread. The home did not have a history of non-compliance related to this issue but did have a history of other unrelated non-compliance. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

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 : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, implement and submit a plan for achieving compliance with LTCHA, 2007 S.O. 2007,c.8, s.6 (10) (c) regarding ensuring that resident #001 is reassessed and the plan of care reviewed and revised to ensure the care provided to the resident is effective.

The plan must confirm that resident #001 will be reassessed and the plan of care reviewed and revised to ensure the care provided is effective.

The plan must identify when and how staff will be provided education related to resident #001's revised plan of care and who will be responsible for providing this education.

The plan must identify but not be limited to the following:
-a process for identifying and monitoring the care provided to resident #001 related to responsive behaviours and
- who will be responsible for monitoring the documentation related to the care provided to the resident.

The plan must also identify who will be responsible for completing the identified tasks and time frames when each of the components will be achieved.

Please submit the written plan to Ruth Hildebrand, Long-Term Care Homes Inspector - Dietary, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 130 Dufferin Ave, 4th Floor, London, ON N6A 5R2, via email by December 30, 2015.

Grounds / Motifs :

1. The licensee has a history of non-compliance with plan of care being reviewed and revised:

A written notification was previously issued March 4, 2013 under Log #L-000088 -13, L-000095-13, L-000095-13 and L-000109-13 and Inspection #2013_185112_0019.

The licensee has failed to ensure that when each resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan was not effective.

A clinical record review revealed that the resident assessment protocol(RAP), in

GoldCare, indicated that resident #001 displayed responsive behaviours.

The functional rehab/restorative care plan RAP indicated that resident #001's involvement in participating with his/her activities varied on his/her mood that day.

A review of the current GoldCare progress notes revealed that there was ongoing documentation, as well as notes on three identified dates and twice on a fourth date, in regard to the resident's responsive behaviours.

During interviews two personal support workers and a registered practical nurse indicated that resident #001 has had " behaviours" since admission, approximately five years ago, but indicated the responsive behaviours have "progressively gotten worse".
Six personal support workers and four registered practical nurses expressed concerns related to behaviours exhibited by the resident.

The care plan, with an identified date, indicated that there were interventions related to the resident's responsive behaviours.

The General Manager indicated that resident #001 had "one good day every 60 days".

A registered practical nurse confirmed that the home did not do daily observation sheet (DOS) charting to demonstrate the frequency, severity, patterns of behaviours for resident #001. The registered practical nurse indicated that they only did DOS charting when requested for abnormal behaviours.

Despite, ongoing documentation of resident #001 demonstrating responsive behaviours, there was no evidence to support that the resident was being supported by the home's Behavioural Support Ontario (BSO) team.
An interview was conducted with the Director of Nursing present and the BSO lead for an identified neighbourhood. The registered practical nurse/ BSO team lead indicated that a referral had not been sent for resident #001 since he/she commenced the position. The team lead indicated no awareness of resident #001 ever being followed by the BSO team. The registered practical nurse indicated that as far as he/she was aware, the neighbourhood was "managing the behaviours well".

A clinical record review revealed that resident #001 had been seen by the Specialized Geriatric Services/Regional Geriatric Program for medical issues, on a specified date, but a referral had not been made for behavioural concerns.

The General Manager confirmed that the referral on the specified date had been related to medical issues.

The General Manager acknowledged that the care set out in the plan of care had not been effective related to responsive behaviours and that it needed to be reviewed and revised.

The severity of the resident not being reassessed when the care was not effective was determined to be actual harm related to the outcome negatively affecting the resident's ability to achieve his/her highest functional status. The scope of the issue was isolated. The home had a history of related and multiple unrelated non-compliance. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

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 : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee must ensure compliance with O. Reg. 79/10, s. 71 (3) to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner and a snack in the afternoon and evening.

The licensee must initiate steps immediately to ensure that all residents are offered between meal beverages in the morning and afternoon and a beverage in the evening after dinner as well as snacks in the afternoon and evening.

The licensee must educate direct care staff regarding the expectations related to ensuring that all residents are offered between meal beverages and snacks, especially in regard to residents who are sleeping.

The licensee must develop and document a monitoring system to ensure that beverages and snacks are offered to all residents.
The licensee must identify and document who is responsible for the ongoing monitoring.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner as well as a snack in the afternoon and evening.

On an identified date, a personal support worker was observed to enter the room of resident #001 with a glass of juice. When the resident was observed to be sleeping the personal support worker stated "oh he/she is sleeping, I will come back later". No attempt was made to rouse the resident who was noted to be at high nutritional risk and 7.7 kilograms below the identified goal weight in the plan of care.
Later that day, the same personal support worker acknowledged that no further attempts were made to offer resident #001 an afternoon beverage or snack.

During the evening snack observation, initiated at 20:15, on an identified date, it was noted that nine residents were not offered a beverage or a snack. The personal support worker indicated that these residents were sleeping. Two additional residents were offered a beverage but no snack and one resident was offered a snack but no beverage. Of the 19 residents observed 11 were not offered a snack (58%) and 10 were not offered a beverage (53%). Four residents refused a snack and beverage.

The personal support worker serving the evening snack cart indicated that sleeping residents were not provided with a beverage or snack.

The Director of Care indicated the expectation was that each resident should be offered a beverage in the morning, as well as an afternoon and evening snack and beverage. She indicated, however, that it was not the expectation that every resident be wakened during evening snack. She indicated that the expectation was that the snack cart was to be delivered at 19:00 or 19:30 at the latest to avoid so many residents being asleep.

The severity of the issue was potential for harm and the scope of the issue was a pattern. The home did not have a history of non-compliance related to this issue but did have a history of other unrelated non-compliance. (128)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

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 : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee must ensure compliance with O. Reg. 79/10, s. 72 (2) in regard to developing production sheets for all menus as part of the food production system.

Production sheets must be developed and implemented for all menus, including snack menus.

A documented monitoring system must be implemented to ensure that there is a process in place to audit that adequate quantities of food are provided as per the planned menu at all meals and snacks.

The licensee must identify, in writing, who will be responsible for the monitoring system.

Grounds / Motifs :

1. The licensee has failed to ensure that the food production system provided for production sheets for snack menus and that all menu items were prepared according to the planned menu.

Observation of the evening snack, on an identified date, revealed that all of the required items as per the menu were not on the snack cart and/or in the necessary quantities. The menu indicated that assorted sandwiches, fresh fruit, apple drink, tea, coffee, and milk were on the menu.

The food observed on the snack cart was 17 quarter sandwiches, a bowl of fresh fruit, two unlabelled pureed texture snacks, one labelled pureed texture cookie, one labelled thickened fluid, one labelled apple juice, one labelled fruit cup, and two and a half sandwiches labelled for individual residents. There was also a jug of diet apple drink, coffee, tea and milk on the snack cart. The cart did not contain any regular apple drink.

A personal support worker confirmed the contents of the snack cart and indicated that the sandwiches were not labelled so the type of sandwich was unknown. The PSW also confirmed that neither a diet list nor menu were on the snack cart.

A diet list in the identified neighbourhood servery revealed that there were 26 residents on minced and regular texture diets. The menu indicated that each resident was to receive a half assorted sandwich for evening snack and residents on diabetic and renal diets were to receive low calorie apple drink. The diet list indicated that 24 residents were to receive regular apple drink and the eight residents were to receive the low calorie beverage. The diet list also indicated that there were seven residents on thickened fluids.

The Director of Food Services acknowledged that the home did not have production sheets to guide the quantities required for food production and items to be prepared for snacks. She indicated that a diet census count sheet was used to determine what should be on the snack cart. She confirmed that there should have been the equivalent of 13 full sandwiches/26 half sandwiches on the evening snack cart. She confirmed that the labelled sandwiches along with the 17 quarter sandwiches provided were inadequate in quantity. This was 52 per cent of the required amount. The Director of Food Services confirmed that there were five residents on a pureed texture and that the three pureed snacks would have been an inadequate quantity. She also confirmed that the personal support workers were responsible for making the thickened fluids using a thickening agent and the thickener should have been available on the snack cart to ensure residents requiring thickened fluids received them.

A review of the undated diet census count sheet revealed that it indicated that there were four residents on thickened fluids but it did not coincide with the diet list which indicated that seven residents required thickened fluids.
The Director of Food Services acknowledged that the numbers on the diet census count sheet were incorrect as seven residents required thickened fluids.
The Director of Food Services indicated that production sheets were required to ensure adequate quantities of food were prepared and that all menu items need to be prepared according to the planned menu.

The severity of the issue was potential for harm and the scope of the issue was a pattern with the potential to affect the whole home. The home did not have a history of non-compliance related to this issue but did have a history of other unrelated non-compliance. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 29, 2016

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 : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must ensure compliance with O. Reg. 79/10, s. 68 (2) in regard to the development and implementation, in consultation with the 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.

The licensee must develop and implement a policy, in consultation with the home's registered dietitian related to proper feeding techniques, including safe positioning of residents who require assistance with eating/drinking.

The licensee must provide education to all direct care staff related to the home's policy that includes safe positioning of residents who require assistance with eating/drinking and keep a written record of the education provided.

A documented monitoring system must be developed to ensure proper techniques are used to assist residents with eating/drinking, including safe positioning of residents who require assistance, including at medication passes.

The licensee must identify who is responsible for the ongoing monitoring.

Grounds / Motifs :

1. The licensee has failed to ensure that the nutrition care and hydration programs included the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration.

There was no documented evidence to support that as part of the dietary services/dining and snack service, the home had a policy related to ensuring that proper techniques were used to assist residents with eating/drinking, including safe positioning of residents who required assistance.

During an interview, the Director of Nursing indicated that the home did not have a policy related to proper techniques to assist residents with eating, including safe positioning and that the home did not do training on this because staff should know this as they are taught this in school.

Inspector #128 indicated to the home that three instances of unsafe positioning, while assisting residents' with eating, had been observed the previous day. Two of the instances were in regard to resident #001. This resident was noted to be at high nutritional risk and had documentation in the clinical record written, on an identified date, by the physician indicating that the resident needed to be upright while being assisted with eating/drinking.

The Director of Food Services also confirmed that the home did not have a dietary policy related to safe eating and acknowledged this was a requirement in the legislation and that the home should have a policy as part of the dietary services program.

The severity of the issue was potential for harm and the scope of the issue was widespread as it potentially affects all residents requiring assistance with eating/drinking. The home did not have a history of non-compliance related to this issue but did have a history of other unrelated non-compliance. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

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

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 18th day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUTH HILDEBRAND

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