Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2021	2021_595110_0012	008937-21, 011205-21	Complaint

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South Whitby ON L1N 9W2

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

Glen Hill Terrace
80 Glen Hill Drive Whitby ON L1N 7A3

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

DIANE BROWN (110)

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): August 19, 23 – 27, 2021. September 8, 9, 10, 15, 2021.

The following concerns were inspected during this complaint inspection:
Log #008937-21 - Lack of COVID active screening for staff, lack of adequate staffing to support resident's care needs; concerns related to response time and an ineffective call bell communication system.
Log #011205-21 - Insufficient staffing with current levels not meeting the resident's daily care needs.
Log #008982-21 - Resident care needs are not being met related to inadequate staffing; concerns related to the home's call bell communication system with extended call bell response times and non- functioning pagers. Concerns related to no menus for those resident's with special dietary needs.
Log #013507-21 - Insufficient staffing and extended wait times for response when residents activate call bells for assistance.

A Cooling and Air Temperature and Infection Prevention and Control Inspection was also completed.

During the course of this inspection the inspector observed infection prevention and control practices, monitoring of air temperature, resident and staff interactions and health record reviews. Conducted resident observations, dining observation and food production area observations reviewed polices, menus and call bell response reports.

During the course of the inspection, the inspector(s) spoke with Administrator, acting Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Business Coordinator, Facility Manager, Dietary Manager, Registered Dieititian, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Activity Aide, Dietary Aide, Housekeeping Staff(ES), Residents and Substitute Decision Makers.

The following Inspection Protocols were used during this inspection:

Food Quality
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Resident Charges
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **2 VPC(s)**
- **7 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	Légende 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Complaints were received by the Ministry of Long -Term Care (LTC) with insufficient

staffing concerns and unsafe staff response time to call bells leading residents to feeling unsafe in the LTC home.

a. Resident #010 reported to the Inspector that they fell out of bed, rang the call bell and no one came for what seemed like an hour even after them shouting for help. A call bell record confirmed that the resident rang and the response time was extensive.

An interview with a PSW stated that when they arrived on shift they completed rounds with their coworker when they heard someone shouting for help. The PSW entered the residents room to find them on the floor and upset. The staff sought registered staff assistance. The PSW stated that the call bell panel was flashing confirming the resident had activated the communication system. The staff also confirmed that they had only one pager for three staff that shift and the one pager did not alert them to the resident's call.

A review of the post fall assessment completed by a registered staff confirmed that resident had fallen out of bed as described by the resident. The documented reason for the fall included ‘did not call for help’. The registered staff was unable to be interviewed.

Staff interviews with afternoon PSWs, during the inspection, revealed the staff had only one pager for three staff on the unit and each staff was to have their own pager.

b. Resident #001 reported to Inspector that there was not enough staff and shared their impressions of what it was like when staff do not have time to engage them. The resident further shared the night prior, after ringing the call bell, the staff came in and turned off the alarm and went back out without asking the resident why they had called. The resident expressed that they felt afraid and sometimes it was past 30 minutes before someone responded to the call bell. The resident then shared a time when they waited well over 30 minutes to be removed from the toilet after activating, several times, the call bell and calling out for help . A nearby staff shared that they heard the resident call 'help' from their office. When they arrived they described the resident as hysterical, in tears, stating they had waited an extended period of time to be removed from the toilet. An interview with a PSW, who worked that shift, confirmed the resident was left on the toilet for 45 minutes to one hour. Another staff shared knowledge of a time when resident #001 had rang the call bell and waited so long to toilet that they had an accident. This staff stated they had toileted the resident on many occasions because of the delay and lack of PSW staffing.

c. An interview with resident #002 shared that they rely on the call bell communication

system for help and they could typically wait 20 minutes for someone to respond. The resident stated that if they have fallen out of bed and was hurt, 20 minutes would be a long time. The resident expressed that the home needed to create an environment of safety and the staff response time was important part of that environment.

d. An interview with resident #020 shared that they require assistance from staff for transfers and toileting. One day they rang and staff did not respond for over three hours as they had timed it and had a record. . The resident shared what concerned them was 'the staff don't even know why they are calling' and they respond hours later.

Sources: Resident interviews, Staff interviews, Record review, call bell communication response report. [s. 5.]

2. A complaint was received by the Ministry of LTC that the home was not actively screening day staff, including agency staff, at the beginning of their shift. Day shift was confirmed to begin at 0600hrs.

As per Directive #3, in effect on December 7, 2020, as issued by the Chief Medical Officer of Health, Long-Term Care homes must actively screen All Persons (including Staff and Visitors) for symptoms and exposure history for COVID-19 before they are allowed to enter the home.

The Inspector arrived to the home at 0555hrs on August 19, 2021, via the staff entrance. A PSW, #100, observed the Inspector and stated that staff complete an on-line survey at home prior to their shift but confirmed there was no active screener present.

The Inspector requested to speak to the nurse in charge. RPN #103 stated that since staff did not require the rapid testing, about 2 months ago, the home stopped having an active screener when you entered in the morning. The staff was unsure of testing requirements of those
unvaccinated staff or essential visitors

An interview with the Assistant Director of Care (ADOC) and Lead of Infection Prevention stated that the home has an on-line survey that staff fill in at home prior to arriving but confirmed that someone should have been present to actively screen, confirm the survey results and PCR testing requirements and to ensure they have a negative COVID-19 test upon entering. The ADOC stated that all unvaccinated employees required to be swabbed daily upon entering. The ADOC identified two unvaccinated staff had entered

the home that morning without a PCR test.

The lack of confirming day staff, including agency and the Inspector having a negative COVID-19 test and not testing positive, presented a risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective as of December 7, 2020), Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes (effective February 16, 2021), Home policy VIII-E-10.12 Coronavirus Screening, On-line staff FirstScreen Self Assessment tool, Interviews with PSW #101, #100, #102, RPN #103, DOC, ADOC, Lead of infection Prevention and Control. [s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that an individualized menu was developed for the resident when their needs cannot be met through the homes' menu cycle.

The Ministry of LTC received complaints that residents requiring therapeutic diets did not have menus to support their nutritional needs.

Staff interviews identified resident #010 as often having very little to eat at mealtimes. An interview with the resident revealed that at their previous LTC home they had an individualized menu, based on their dietary restrictions, but at Glen Hill Terrace they could only eat about 30 percent of what was offered on the regular menu. The resident's weight revealed a significant weight loss over two month and since their admission weight . A review of the plan of care and dietitian assessment identified reference to a

personalized menu, but an individualized/personalized menu was not in place.

Sources: Resident interview, PSW interviews, Dietary Manager and Registered Dietitian interviews, written plan of care, diet type report, Weight summary report, mealtime and kitchen observations. [s. 71. (5)]

2. Staff interviews identified that resident #008 required a therapeutic, renal diet but had no individualized menu guiding what the resident could eat.

A PSW shared that staff provided the resident with the same thing all the time. Another PSW #100 revealed that the resident did not have a therapeutic diet menu and that PSWs tell the dietary aides what to serve stating the resident was not to have a food item and dietary served the resident this item. A mealtime observation confirmed the lack of an individualized therapeutic diet menu and the offering of unsuitable menu items to the resident. An interview with the resident after the lunch meal observation revealed that they were aware they were not to have the menu item on their diet but stated there was no alternative. The resident also stated they did not have a special menu and at times felt hungry after a meal as regular menu items were often removed but not replaced with a suitable alternative to meet their therapeutic needs..

Sources: Mealtime observations on September 9, 2021, resident interview, staff interviews including the Dietary Manager, Registered Dietitian and PSWs. Written plan of care. [s. 71. (5)]

3. The LTC home Inspector reviewed resident #009's plan of care revealing the direction for a therapeutic diet. A mealtime observation revealed the resident being was served and consumed foods and fluids not suitable to meet their therapeutic dietary needs. An interview with s dietary aide and the dietary manager confirmed that individualized menus, like for those requiring a the identified diet were not available.

Sources: written plan of care, interview with registered dietitian, dietary manager, PSWs and dietary aide and mealtime observations. [s. 71. (5)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

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

Complaints were received by the Ministry of LTC concerning the poor quality of minced and pureed food being served to residents.

On September 8, 2021, lunch meal service was observed and at the end of the service menu items including minced and pureed foods were taste tested.

The regular menu, was expected to be modified to minced and pureed textures, according to dietary staff, explaining why a separate minced and pureed menu was not available or posted.

The lunch menu included two choices: Caribbean marinated chicken (chicken thigh, allspice, ginger, lemon juice and herbs), rice and beans and creamy rainbow coleslaw or a salmon patty with yogurt parsley and lemon sauce with a mixed green salad.
The minced foods were taste tested along with dietary aide #119 and determined to be a plain, bland, minced chicken served with mashed potatoes and a glue consistency minced coleslaw, not equivalent in taste, appearance or nutritive value to the planned menu of Caribbean marinated chicken, rice and beans and creamy rainbow coleslaw.
The second choice of the salmon patty was served with an unknown minced green food. The dietary aide was unsure, the dietary manager stated it was salad and a taste tested

with dietary aide #119 and Inspector revealed it was broccoli. The pureed meal was equally as bland, plain pureed chicken served with mashed potatoes and the second choice was a flavorless fish with mashed potatoes and an unknown pureed green vegetable determined by taste to be pureed broccoli. The items served not equivalent in taste, appearance or nutritive value to the planned menu of Caribbean marinated chicken rice and beans and creamy rainbow coleslaw and salmon patty with yogurt parsley and lemon sauce and a mixed green salad.

On September 8, 2021 dinner meal service was observed and at the end of meal service menu items including minced and pureed foods were again taste tested.

The dinner menu included two choices: garlic shrimp fettuccine Alfredo with green and red leaf salad and Mediterranean stuffed peppers with a spinach salad both of which were taste tested.The minced foods served when taste tested were determined to be plain, bland, minced shrimp served with mashed potatoes and minced carrots and plain, bland minced turkey with mashed potatoes and minced spinach; both choices were not equivalent in taste, appearance or nutritive value to the planned menu of garlic shrimp fettuccine Alfredo and Mediterranean stuffed peppers. The pureed shrimp taste tested revealed a bland, unidentifiable in flavour food, served with mashed potatoes and pureed carrot. A second choice of pureed Mediterranean stuffed peppers was not available.

On September 9, 2021 a third meal was observed and at the end of the service menu items including minced and pureed foods were taste tested.

The lunch menu included two choices; perogies with cheese and sour cream and kale salad or a roast turkey plus swiss sandwich with creamy cucumber salad.
The minced foods were taste tested along with dietary aide #119 and determined to be a bland, gluey, unappetizing serving of minced perogies along with minced plain kale. The pureed perogies were also gluey, tasteless and unappetizing and served with an unknown green vegetable, taste tested and determined to be cold pureed cooked broccoli. The minced and pureed mandarin oranges served were also taste tested by Inspector and dietary aide and described by an unappealing gluey consistency, translucent from thickener with a diluted, undetectable orange flavor.

Staff and resident interviews expressed concern around the unappetizing appearance and taste of minced and pureed meals over the course of the inspection.

Sources: Meal service observations and taste testing, menu review, resident and staff

interviews. [s. 72. (3) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care based on an interdisciplinary assessment of the resident's sleep patterns and preference.

The Ministry of LTC received several complaints related to resident care needs not being met.

Staff identified that residents, like resident #014, would like to rest in their bed after meals and confirmed that their plan of care did not direct staff, including agency staff, of the residents rest preferences. The resident was observed sitting in the lounge area after lunch and confirmed with the Inspector that they'd like to go back to bed after meals. A record review failed to include sleep patterns and preference in the resident's plan of care. [s. 26. (3) 21.]

2. Staff identified that resident #013 would like to rest in their bed after meals and

confirmed that their plan of care did not direct staff, including agency staff, of the resident's rest preference. The resident was observed sitting in the lounge area late morning and on another day mid afternoon. An interview was held with the resident and they confirmed they would like to go back to bed after meals. A record review failed to include sleep patterns and preference in the resident's plan of care. [s. 26. (3) 21.]

3. Staff identified resident #007 that should be placed back to bed after breakfast and now they are staying up until after lunch because of insufficient staff. A review of the resident's plan of care failed to include an interdisciplinary assessment of the resident's sleep patterns and preferences to direct staff, including agency staff of the residents rest preference.

Sources: Staff interviews PSW #112, #108, RPN #103, resident observation and the written plan of care. [s. 26. (3) 21.]

4. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home complete a nutritional assessment for the resident on admission and assess the resident's hydration status, and any risks related to hydration.

Resident #002’s weight increased their estimated fluid requirement to above 2500mls per day based on Best Practice calculations. The hydration program according to the home’s policy stated residents are offered a minimum of 1500-2000mls of fluid daily. The resident’s access to their higher fluid intake outside of the planned menus was not assessed and addressed at a potential risk factor of dehydration.

Resident #002’s health records identified a current diagnosis with treatment for a urinary tract infection (UTI). The resident’s health record also revealed the lack of fluid monitoring. A further risk to resident #002 hydration status was identified when the home routinely served significantly less fluids/beverages at meals than identified in the homes' Hydration Program. [s. 26. (4)]

5. A record review and interview with the Registered Dietitian identified the lack of an individualized estimated fluid requirement for each resident, including resident #012 at part of a complete a nutritional assessment for the resident on admission. The assessment also failed to include an assessment of the resident's hydration status and and risks to their hydration. [s. 26. (4)]

6. A record review and interview with the Registered Dietitian identified the lack of an

individualized, estimated fluid requirement for each resident including resident #011 as part of a complete nutritional assessment for the resident on admission. The assessment also failed to include an assessment of the resident's hydration status and any risks to their hydration including resident #011's diagnosis and the provision of a modified fluid consistency diet .

Sources: Resident's daily food and fluid intake record, health record, mealtime observations, Best Practice for Nutrition, Food Service and Dining in LTC Homes, Dietitians of Canada 2019. Home's Hydration Policy XI_H_60.00, April 2021. Interview with PSWs, Registered Dietitian and Manager of Food Service. [s. 26. (4)]

Additional Required Actions:

CO # - 004 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. 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 licensee has failed to ensure that the 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, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Complaints were received by the Ministry of Long-Term Care that resident's care needs were not being met including the requirement to offer residents bathing twice a week.

Staff interviews identified that with staffing shortages they were unable to always provide residents with two bathing opportunities per week and identified resident #007 as a resident who has been impacted.

A record review of resident #007's September, 2021, The Observation Record, where PSWs document when the bathing task has been completed, identified that the resident was not provided two baths between September 1 and September 8, 2021 which was also confirmed by PSW #107. [s. 33. (1)]

2. Interviews with staff confirmed that residents were not bathed twice a week related to the staffing levels in the home. PSW #106 identified that with only two PSWs working and not the scheduled three that resident bathing was impacted. Resident #019 was identified as not receiving their regular twice a week bathing preference of a shower. Resident #019's August 2021 Observation Record was not available to the Inspector for review. A review of the July 2021 record confirmed that resident #019 had received two showers in the month of July and three bed baths and not the required eight showers in the month. [s. 33. (1)]

3. Interviews with staff confirmed that residents were not bathed twice a week related to the staffing levels in the home. PSW #105 identified that resident #018 has gone seven days with giving their preferred bed bath. PSW #106 stated that resident #018's bed bath often gets missed when staffing was not at the planned level. A record review identified that a bed bath had not been provided between September 1 and the September 8, 2021 at the time of inspection and staff interviews.

Sources: Record review of Observations Records and staff PSW #105, #107 and #106 interviews. [s. 33. (1)]

Additional Required Actions:

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

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Complaints were received by the Ministry of Long-Term Care that resident care needs were not being met.

A tour of the home was conducted. Resident #015 permitted the Inspector to look at their feet and PSW #112 removed the resident's socks and shoes. The resident's toenails were up to one inch in length with one toenail curled under the toe and touching the resident's skin. The resident could not recall the last time their toenails were cut and expressed concern that the long curled nail would soon cut through their skin.

Staff interviews confirmed that PSWs were not trimming the residents toe nails, that foot care services, paid for by the resident, were interrupted as a result of the COVID pandemic. An interview with the Business Coordinator #104 confirmed that PSW staff were not trimming resident toenails and that residents were advised to sign up for foot care services at a fee or could make other arrangements. [s. 35. (1)]

2. Resident #016 was observed walking with open toe sandals. The resident's toenails were approximately one inch in length. The resident stated they are a bit too long. PSW #100 confirmed the residents toenails were long but that PSWs were not responsible for cutting toenails, just finger nails. On September 9, 2021 the resident was again observed and their toenails remained long and untrimmed. The RN #118 described the resident's toenails as 'very long' and thought the foot care nurse came every 6 weeks. [s. 35. (1)]

3. Resident #017's toenails were observed along with PSW #112. They were long, untrimmed and approximately one half inch in length and curling up. The RPN #103 confirmed that the resident's toenails required trimming.

Sources: Resident observations, PSW and registered staff interviews. Review of resident's unfunded services agreement. [s. 35. (1)]

Additional Required Actions:

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

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 home's 'Hydration Program Policy' identified the fluids required to be offered at meals, breakfast, lunch and evening meal along with the amount at AM, PM and Evening snacks.

The home's policy directed the following to be offered or the alternative of preferred fluids.
Breakfast-250mls milk, 125mls juice, 125mls water and 125mls coffee or tea.
Lunch – 125mls milk, 125mls water and 125mls coffee or tea.
Dinner - 125mls milk, 125mls water and 125mls coffee or tea.

Meal service observations were conducted over the course of two days and revealed one glass, typically juice being offered along with coffee or tea to those requesting it. Milk and water were not observed being offered or served. Resident #012, non verbal and requiring total feeding assistance was identified at lunch to be served one glass of

cranberry juice. The lunch standard identified in the home's hydration program policy includes 125mls milk, 125mls water and 125mls coffee or tea.

PSW interviews confirmed there was no standard in place as to what fluids should be served and that one glass was usually offered along with coffee or tea if the resident requested. Staff also confirmed that milk was seldom served.

Sources: Meal service observations, PSW interviews, #105, #115, #108, #007, #123, Dietary Manager and Registered Dietitian. The Home’s Hydration Program Policy XI-H-60.00 dated April 2021. [s. 68. (2) (a)]

2. The licensee has failed to ensure that there a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Resident #002 identified at high nutritional risk did not have their food and fluid intake monitored and evaluated. A record review identified incomplete 'resident daily food and fluid intake records' with significant gaps of missing information. Resident #002 was being treated for a urinary tract infection (UTI) with a lack of fluid monitoring and evaluation. Registered staff were unaware of who monitored and evaluated intake records and when to refer to the registered dietitian. [s. 68. (2) (d)]

3. Resident #012 identified at high nutritional risk did not have their food and fluid intake monitored and evaluated. A record review identified incomplete 'resident daily food and fluid intake records' with significant gaps of missing information. Resident #012, requiring total feeding assistance, was observed at lunch being served one glass of cranberry juice, well below the standard in the home’s hydration program. A further record review identified a nurse practitioner’s note that the resident had increased lethargy and to push fluids. [s. 68. (2) (d)]

4. Resident #011 identified at high nutritional risk did not have their food and fluid intake monitored and evaluated. A record review identified incomplete 'resident daily food and fluid intake records' with significant gaps of missing information. Resident's diagnosis and the provision of a modified fluid consistency diet were risk factors for dehydration. [s. 68. (2) (d)]

5. Resident #010 identified at high nutritional risk did not have their food and fluid intake monitored and evaluated. The resident's plan of care identified Resident #010 identified at high nutritional risk did not have their food and fluid intake monitored and evaluated.

The resident's plan of care identified their risk of lower fluid intakes and subsequent risk of dehydration however the record review identified incomplete 'resident daily food and fluid intake records' with significant gaps of missing information. Registered staff interviews revealed a lack of awareness of the home's system to monitor and evaluate a resident's fluid intake.

Sources: Lunch meal observation, Interview with PSW #124, #108, RPN #121 and #103 and the Registered Dietitian. Progress notes, Resident Daily Food and Fluid intake records. [s. 68. (2) (d)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other.

The Ministry of LTC received complaints that residents requiring therapeutic diets did not have menus to support their nutritional needs.

Resident #005's plan of care identified their diagnosis and need for a diet restriction. Interviews with PSWs and activation aides revealed that dietary staff are often unaware of what to serve resident #005 at meal time with no menu. PSWs stated they show the resident an ipad with pictures of the regular menu choices but often the resident can't have the choices presented because of their dietary restrictions. An interview with the dietary aide serving was unaware of a menu stating the chef always provided a choice. The dietary aide further stated what the resident was served at lunch but was unsure if any condiments were suitable on the diet. An interview with the Dietary Manager stated there was a menu for resident #005 in the kitchen. Upon review of the menu the resident was to be served an item that was not provided or offered to the resident at the meal observed.

Sources: Interviews PSWs #108, dietary aide #126, observations at meal times and in the kitchen. [s. 6. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #9: 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 are used to assist the resident with eating, including safe positioning of residents who require assistance.

During a lunch meal service resident #011 was observed in the dining room being totally assisted with their meal while in a high risk, unsafe position. The resident's chair was titled back placing the resident in a 60-70 degree angle and looking upwards towards the ceiling while being fed. The Inspector approached PSW #113 who was unaware of how to address the resident's position and chair. The Inspector spoke with RN #120 who immediately intervened stating a resident could not swallow in that position.

The resident's health record identified the resident at high nutritional risk related to swallowing and chokes easily. A progress note, a month prior, documented the resident coughing during lunch time and the writer noticed their chair was not in an upright position. The team was reminded to have the resident sit upright during meals.

Sources: Resident mealtime observation, staff interviews RN #120, PSWs, #113, written plan of care. [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 the resident with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

Issued on this 14th day of December, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	DIANE BROWN (110)
Inspection No. / No de l’inspection :	2021_595110_0012
Log No. / No de registre :	008937-21, 011205-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 23, 2021
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, Whitby, ON, L1N-9W2
LTC Home / Foyer de SLD :	Glen Hill Terrace 80 Glen Hill Drive, Whitby, ON, L1N-7A3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Elisa Robinson

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCH Act.

Specifically, the licensee must:
1. Ensure the homes' communication response system is operational and all front line staff are provided with a required pager and education on the use of the pagers.
2. Ensure the home is a safe environment for residents by way of responding to the care needs of residents in an acceptable, timely, manner.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Complaints were received by the Ministry of Long -Term Care (LTC) with insufficient staffing concerns and unsafe staff response time to call bells leading residents to feeling unsafe in the LTC home.

a. Resident #010 reported to the Inspector that they fell out of bed, rang the call bell and no one came for what seemed like an hour even after them shouting for help. A call bell record confirmed that the resident rang and the response time was extensive.

An interview with a PSW stated that when they arrived on shift they completed rounds with their coworker when they heard someone shouting for help. The PSW entered the residents room to find them on the floor and upset. The staff sought registered staff assistance. The PSW stated that the call bell panel was flashing confirming the resident had activated the communication system. The

staff also confirmed that they had only one pager for three staff that shift and the one pager did not alert them to the resident's call.

A review of the post fall assessment completed by a registered staff confirmed that resident had fallen out of bed as described by the resident. The documented reason for the fall included 'did not call for help'. The registered staff was unable to be interviewed.

Staff interviews with afternoon PSWs, during the inspection, revealed the staff had only one pager for three staff on the unit and each staff was to have their own pager.

b. Resident #001 reported to Inspector that there was not enough staff and shared their impressions of what it was like when staff do not have time to engage them. The resident further shared the night prior, after ringing the call bell, the staff came in and turned off the alarm and went back out without asking the resident why they had called. The resident expressed that they felt afraid and sometimes it was past 30 minutes before someone responded to the call bell. The resident then shared a time when they waited well over 30 minutes to be removed from the toilet after activating, several times, the call bell and calling out for help . A nearby staff shared that they heard the resident call 'help' from their office. When they arrived they described the resident as hysterical, in tears, stating they had waited an extended period of time to be removed from the toilet. An interview with a PSW, who worked that shift, confirmed the resident was left on the toilet for 45 minutes to one hour. Another staff shared knowledge of a time when resident #001 had rang the call bell and waited so long to toilet that they had an accident. This staff stated they had toileted the resident on many occasions because of the delay and lack of PSW staffing.

c. An interview with resident #002 shared that they rely on the call bell communication system for help and they could typically wait 20 minutes for someone to respond. The resident stated that if they have fallen out of bed and was hurt, 20 minutes would be a long time. The resident expressed that the home needed to create an environment of safety and the staff response time was important part of that environment.

d. An interview with resident #020 shared that they require assistance from staff

for transfers and toileting. One day they rang and staff did not respond for over three hours as they had timed it and had a record. The resident shared what concerned them 'the staff don't even know why they are calling and they respond hours later'.

Sources: Resident interviews, Staff interviews, Record review, call bell communication response report. [s. 5.]

An Order was made by taking the following factors into account:

Severity: There was actual risk of harm to resident's #010, #001 and #020, in the long delay in responding to the resident's call bell, by creating the resident's feeling of an unsafe home environment and staff were unaware of the nature of why the resident was calling.
Scope: The scope of this non-compliance was widespread as three out of three residents inspected confirmed their experiences and their sense of an unsafe feeling with respect to the lack of a timely response to calling for assistance.
Compliance History: The licensee has a past non-compliance to a different subsection. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 71 (5).

Specifically, the licensee must:

1. Ensure that all residents with therapeutic diets whose needs can not be met through the home's regular menu are provided with an individualized menu.
2. Any resident whose nutritional needs can not be met through the regular menu related to a preference for vegetarian menu or related to multiple food restrictions shall have an individualized menu developed.

Grounds / Motifs :

1. The licensee has failed to ensure that an individualized menu was developed for the resident when their needs cannot be met through the homes' menu cycle.

The Ministry of LTC received complaints that residents requiring therapeutic diets did not have menus to support their nutritional needs.

Staff interviews identified resident #010 as often having very little to eat at mealtimes. An interview with the resident revealed that at their previous LTC home they had an individualized menu, based on their dietary restrictions, but at Glen Hill Terrace they could only eat about 30 percent of what was offered on the regular menu. The resident's weight revealed a significant weight loss over two month and since their admission weight . A review of the plan of care and dietitian assessment identified reference to a personalized menu, but an individualized/personalized menu was not in place.

Sources: Resident interview, PSW interviews, Dietary Manager and Registered

Dietitian interviews, written plan of care, diet type report, Weight summary report, mealtime and kitchen observations. [s. 71. (5)]

(110)

2. 2. Staff interviews identified that resident #008 required a therapeutic, renal diet but had no individualized menu guiding what the resident could eat.

A PSW shared that staff provided the resident with the same thing all the time. Another PSW #100 revealed that the resident did not have a therapeutic diet menu and that PSWs tell the dietary aides what to serve stating the resident was not to have a food item and dietary served the resident this item. A mealtime observation confirmed the lack of an individualized therapeutic diet menu and the offering of unsuitable menu items to the resident. An interview with the resident after the lunch meal observation revealed that they were aware they were not to have the menu item on their diet but stated there was no alternative. The resident also stated they did not have a special menu and at times felt hungry after a meal as regular menu items were often removed but not replaced with a suitable alternative to meet their therapeutic needs..

Sources: Mealtime observations on September 9, 2021, resident interview, staff interviews including the Dietary Manager, Registered Dietitian and PSWs. Written plan of care. [s. 71. (5)]

(110)

3. 3. The LTC home Inspector reviewed resident #009's plan of care revealing the direction for a therapeutic diet. A mealtime observation revealed the resident being was served and consumed foods and fluids not suitable to meet their therapeutic dietary needs. An interview with s dietary aide and the dietary manager confirmed that individualized menus, like for those requiring a the identified diet were not available.

Sources: written plan of care, interview with registered dietitian, dietary manager, PSWs and dietary aide and mealtime observations. [s. 71. (5)]

Ontario

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Ministère des Soins de longue durée

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

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

An Order was made by taking the following factors into account:

Severity: There was actual risk of harm to resident's #010, #008 and #009 in that diet therapy, an individualized menu, as directed by the registered dietitian was not in place to support the resident's health and well-being.
Scope: The scope of this non-compliance was widespread as three out of three residents inspected lacked an individualized menu to support their health and well-being.
Compliance History: The licensee has a past non-compliance to a different subsection. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 22, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 72 (3).

Specifically, the licensee must:
1. Ensure that the food production system supports the preparation of quality minced and pureed foods, in keeping with the regular menu.
2. Ensure that all minced and pureed foods are supported by standardized recipes.
3. Upon receipt of this order, the home shall come up with a plan to ensure that minced and pureed foods are equivalent in taste, nutritive value, and quality to the regular menu. The plan shall be available to the Inspector upon follow -up inspection.

Grounds / Motifs :

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

Complaints were received by the Ministry of LTC concerning the poor quality of minced and pureed food being served to residents.

On September 8, 2021, lunch meal service was observed and at the end of the service, menu items including minced and pureed foods were taste tested.

The regular menu, was expected to be modified to minced and pureed textures, according to dietary staff, explaining why a separate minced and pureed menu

was not available or posted.

The lunch menu included two choices: Caribbean marinated chicken (chicken thigh, allspice, ginger, lemon juice and herbs), rice and beans and creamy rainbow coleslaw or a salmon patty with yogurt parsley and lemon sauce with a mixed green salad.
The minced foods were taste tested along with dietary aide #119 and determined to be a plain, bland, minced chicken served with mashed potatoes and a glue consistency minced coleslaw, not equivalent in taste, appearance or nutritive value to the planned menu of Caribbean marinated chicken, rice and beans and creamy rainbow coleslaw. The second choice of the salmon patty was served with an unknown minced green food. The dietary aide was unsure, the dietary manager stated it was salad and a taste tested with dietary aide #119 and Inspector revealed it was broccoli. The pureed meal was equally as bland, with plain pureed chicken served with mashed potatoes. The second choice was a flavorless fish with mashed potatoes and an unknown pureed green vegetable determined by taste to be pureed broccoli. The items served not equivalent in taste, appearance or nutritive value to the regular planned menu.

On September 8, 2021 dinner meal service was observed and at the end of meal service menu items including minced and pureed foods were again taste tested.

The dinner menu included two choices; garlic shrimp fettuccine Alfredo with green and red leaf salad and Mediterranean stuffed peppers with a spinach salad both of which were taste tested. The minced foods served when tasted were determined to be plain, bland, minced shrimp served with mashed potatoes and minced carrots and plain, bland, minced turkey with mashed potatoes and minced spinach. The pureed shrimp taste tested revealed a bland, unidentifiable in flavour food, served with mashed potatoes and pureed carrot. A second choice of pureed Mediterranean stuffed peppers was not available. The minced and pureed menu items were not equivalent in taste, appearance or nutritive value to the planned menu of garlic shrimp fettuccine Alfredo and Mediterranean stuffed peppers.

On September 9, 2021 a third meal was observed and at the end of the service menu items including minced and pureed foods were taste tested.

The lunch menu included two choices: perogies with cheese and sour cream and kale salad or a roast turkey and swiss sandwich with creamy cucumber salad.
The minced foods were taste tested along with dietary aide #119 and determined to be a bland, gluey, unappetizing serving of minced perogies along with minced plain kale. The pureed perogies were also gluey, tasteless and unappetizing and served with an unknown green vegetable that was taste tested and determined to be cold pureed cooked broccoli. The minced and pureed mandarin oranges served were also taste tested by Inspector and dietary aide and described by an unappealing gluey consistency, translucent from thickener with a diluted, undetectable orange flavor.

Staff and resident interviews expressed concern around the unappetizing appearance and taste of minced and pureed meals over the course of the inspection.

Sources: Meal service observations and taste testing, menu review, resident and staff interviews.

An Order was made by taking the following factors into account:

Severity: There was actual risk of harm to resident's in the home requiring a minced and pureed diet as the items prepared and served were not prepared to preserve taste, nutritive value, appearance and food quality, promoting intake and the enjoyment of food.
Scope: The scope of this non-compliance was widespread as all those on minced and pureed textured diets were impacted.
Compliance History: The licensee has a past non-compliance to a different subsection.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2021

Ontario

Ministry of 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

Ministère 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

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Ministère des Soins de longue durée

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Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).
O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee must be complaint with O. Reg. 79/10, s. 26 (4).

Specifically, the licensee must:
1. Ensure the registered dietitian completes an interdisciplinary assessment of the resident's hydration status and any risks related to hydration for all residents on admission and whenever there is a significant change in a resident's health condition.

Grounds / Motifs :

1. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home complete a nutritional assessment for the resident on admission and assess the resident's hydration status, and any risks related to hydration.

Resident #002's weight increased their estimated fluid requirement to above 2500mls per day based on Best Practice calculations. The hydration program according to the home's policy stated residents are offered a minimum of 1500-2000mls of fluid daily. The resident's access to their higher fluid intake outside of the planned menus was not assessed and addressed at a potential risk factor of dehydration.

Resident #002's health records identified a current diagnosis with treatment for a urinary tract infection (UTI). The resident's health record also revealed the lack of fluid monitoring. A further risk to resident #002 hydration status was identified

when the home routinely served significantly less fluids/beverages at meals than identified in the homes' Hydration Program. [s. 26. (4)]

(110)

2. A record review and interview with the Registered Dietitian identified the lack of an individualized estimated fluid requirement for each resident, including resident #012 at part of a complete a nutritional assessment for the resident on admission. The assessment also failed to include an assessment of the resident's hydration status and and risks to their hydration. [s. 26. (4)] (110)

3. A record review and interview with the Registered Dietitian identified the lack of an individualized, estimated fluid requirement for each resident including resident #011 as part of a complete nutritional assessment for the resident on admission. The assessment also failed to include an assessment of the resident's hydration status and any risks to their hydration including resident #011's diagnosis and the provision of a modified fluid consistency diet.

An Order was made by taking the following factors into account:

Severity: There was actual risk of harm to resident's hydration status with a lack an individualized hydration assessment and the failure to identify risk factors of dehydration.
Scope: The scope of this non-compliance was widespread as at least three out of three residents reviewed did not had an individualized hydration assessment.
Compliance History: The licensee has a past non-compliance to a different subsection.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 # / No d'ordre : 005

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 be compliant with O. Reg. 79/10, s. 33 (1).

Specifically, the licensee must:

1. Ensure that the 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, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Grounds / Motifs :

1. The licensee has failed to ensure that the 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, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Complaints were received by the Ministry of Long-Term Care that resident's care needs were not being met including the requirement to offer residents bathing twice a week.

Staff interviews identified that with staffing shortages they were unable to always provide residents with two bathing opportunities per week and identified resident #007 as a resident who has been impacted.

A record review of resident #007's September, 2021, The Observation Record, where PSWs document when the bathing task has been completed, identified

that the resident was not provided two baths between September 1 and September 8, 2021 which was also confirmed by PSW #107. [s. 33. (1)]

(110)

2. Interviews with staff confirmed that residents were not bathed twice a week related to the staffing levels in the home. PSW #105 identified that resident #018 has gone seven days with giving their preferred bed bath. PSW #106 stated that resident #018's bed bath often gets missed when staffing was not at the planned level. A record review identified that a bed bath had not been provided between September 1 and the September 8, 2021 at the time of inspection and staff interviews.

Sources: Record review of Observations Records and staff PSW #105, #107 and #106 interviews. [s. 33. (1)] (110)

3. Interviews with staff confirmed that residents were not bathed twice a week related to the staffing levels in the home. PSW #106 identified that with only two PSWs working and not the scheduled three that resident bathing was impacted. Resident #019 was identified as not receiving their regular twice a week bathing preference of a shower. Resident #019's August 2021 Observation Record was not available to the Inspector for review. A review of the July 2021 record confirmed that resident #019 had received two showers in the month of July and three bed baths and not the required eight showers in the month.

An Order was made by taking the following factors into account:

Severity: There was actual risk of harm of infection prevention to resident's from failing to provide a minimum of twice weekly bathing.
Scope: The scope of this non-compliance was widespread as at least three out of three residents reviewed were not provided with the required bathing.
Compliance History: The licensee has a past non-compliance to a different subsection. (110)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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Vous devez vous conformer à cet ordre d’ici le : Dec 22, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 # / No d'ordre : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 35 (1).

Specifically, the licensee must:

1. Ensure ensure that the resident receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.
2. A resident may not be charged for basic foot and nail care, including the cutting of toenails and fingernails.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Complaints were received by the Ministry of Long-Term Care that resident care needs were not being met.

A tour of the home was conducted. Resident #015 permitted the Inspector to look at their feet and PSW #112 removed the resident's socks and shoes. The resident's toenails were up to one inch in length with one toenail curled under the toe and touching the resident's skin. The resident could not recall the last time their toenails were cut and expressed concern that the long curled nail would soon cut through their skin.

Staff interviews confirmed that PSWs were not trimming the residents toe nails,

that foot care services, paid for by the resident, were interrupted as a result of the COVID pandemic. An interview with the Business Coordinator #104 confirmed that PSW staff were not trimming resident toenails and that residents were advised to sign up for foot care services at a fee or could make other arrangements.
(110)

2. Resident #016 was observed walking with open toe sandals. The resident's toenails were approximately one inch in length. The resident stated they are a bit too long. PSW #100 confirmed the residents toenails were long but that PSWs were not responsible for cutting toenails, just finger nails. On September 9, 2021 the resident was again observed and their toenails remained long and untrimmed. The RN #118 described the resident's toenails as 'very long' and thought the foot care nurse came every 6 weeks.
(110)

3. Resident #017's toenails were observed along with PSW #112. They were long, untrimmed and approximately one half inch in length and curling up. The RPN #103 confirmed that the resident's toenails required trimming.

Sources: Resident observations, PSW and registered staff interviews. Review of resident's unfunded services agreement.

An Order was made by taking the following factors into account:

Severity: There was actual risk of harm of infection prevention, pain and discomfort when failing to provide basic foot care including the cutting of toenails.
Scope: The scope of this non-compliance was widespread as at least three out of three residents reviewed were not provided with the required footcare.
Compliance History: The licensee has a past non-compliance to a different subsection.

(110)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 22, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 007

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 be compliant with O. Reg. 79/10, s. 68 (2).

Specifically, the licensee must:

1. Implement the system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.
2. Implement the home's 'Hydration Program Policy' identified the fluids required to be offered at meals, breakfast, lunch and evening meal along with the amount at AM, PM and Evening snacks.

Grounds / Motifs :

1. The home's 'Hydration Program Policy' identified the fluids required to be offered at meals, breakfast, lunch and evening meal along with the amount at AM, PM and Evening snacks.

The policy directed the following to be offered or the alternative of preferred fluids.
Breakfast - 250mls milk, 125mls juice, 125mls water and 125mls coffee or tea.
Lunch – 125mls milk, 125mls water and 125mls coffee or tea.
Dinner - 125mls milk, 125mls water and 125mls coffee or tea.

Meal service observations were conducted over the course of two days and revealed one glass, typically juice being offered along with coffee or tea to those requesting it. Milk and water were not observed being offered or served. Resident #012, non verbal and requiring total feeding assistance was identified at lunch to be served one glass of cranberry juice. The lunch standard identified in the home's hydration program policy includes 125mls milk, 125mls water and 125mls coffee or tea.

PSW interviews confirmed there was no standard in place as to what fluids should be served and that one glass was usually offered along with coffee or tea if the resident requested. Staff also confirmed that milk was seldom served.

Sources: Meal service observations, PSW interviews, #105, #115, #108, #007, #123, Dietary Manager and Registered Dietitian. The Home's Hydration Program Policy XI-H-60.00 dated April 2021.
(110)

2. The licensee has failed to ensure that there a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Resident #002 identified at high nutritional risk did not have their food and fluid intake monitored and evaluated. A record review identified incomplete 'resident daily food and fluid intake records' with significant gaps of missing information. Resident #002 was being treated for a urinary tract infection (UTI) with a lack of fluid monitoring and evaluation. Registered staff were unaware of who monitored and evaluated intake records and when to refer to the registered dietitian.

(110)

3. Resident #012 identified at high nutritional risk did not have their food and

fluid intake monitored and evaluated. A record review identified incomplete 'resident daily food and fluid intake records' with significant gaps of missing information. Resident #012, requiring total feeding assistance, was observed at lunch being served one glass of cranberry juice, well below the standard in the home's hydration program. A further record review identified a nurse practitioner's note that the resident had increased lethargy and to push fluids. (110)

4. Resident #011 identified at high nutritional risk did not have their food and fluid intake monitored and evaluated. A record review identified incomplete 'resident daily food and fluid intake records' with significant gaps of missing information. Resident's diagnosis and the provision of a modified fluid consistency diet were risk factors for dehydration.

(110)

5. Resident #010 identified at high nutritional risk did not have their food and fluid intake monitored and evaluated. The resident's plan of care identified their risk of lower fluid intakes and subsequent risk of dehydration however record review identified incomplete 'resident daily food and fluid intake records' with significant gaps of missing information. Registered staff interviews revealed a lack of awareness of the home's system to monitor and evaluate a resident's fluid intake.

Sources: Lunch meal observation, Interview with PSW #124, #108, RPN #121 and #103 and the Registered Dietitian. Progress notes, Resident Daily Food and Fluid intake records.

An Order was made by taking the following factors into account:

Severity: There was actual risk of harm of dehydration in failing to provide the minimum amount of fluids according to the homes' policy and failing to monitor

residents fluid intake.
Scope: The scope of this non-compliance was widespread as at least three out of three residents reviewed were not provided with the required bathing.
Compliance History: The licensee has a past non-compliance to a different subsection.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 28, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Diane Brown

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