Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 12, 2017	2017_556168_0014	007448-17	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

DOVER CLIFFS
501 St George Street P.O. BOX 430 Port Dover ON N0A 1N0

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

LISA VINK (168), JESSICA PALADINO (586)

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): May 5, 8, 9, 10, 23 and 24, 2017.

Inspector Lisa Bos participated in this inspection.

This complaint inspection for INFO line number 50280-HA was related to skin and wound, duty to protect, plan of care, residents' drug regimes and nutrition and hydration programs.

The following onsite inquiry was conducted and closed with this complaint inspection:
Log number 1007-17, for INFO line number 48822-HA, related to nursing and personal support services and infection control.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Executive Director, Regional Manager, Education Coordinator, Regional Manager of Education and Resident Services, Food Services Manager, registered nurses (RN), the registered dietitian (RD), personal support workers and residents.

During the course of the inspection, the inspectors observed the provision of care and services and reviewed clinical records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Pain
Personal Support Services
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that the policies and procedures relating to nutrition care and dietary services and hydration were implemented.

The home's policy Food and Fluid Intake Monitoring, CARE7-0.10.02, last revised July 31, 2016, identified that when a resident drank less than their minimal recommended beverage intake for three consecutive days, staff were to assess if the resident showed signs and symptoms of dehydration. If yes, a nutrition care referral was to be sent to the RD and if not, "based on nursing clinical judgment, determine whether or not a Nutrition Care Referral to the RD is required".

A. On May 23, 2017, the FSM indicated that it was currently their responsibility to review fluid intake records of residents on a weekly basis.
This task would often be completed in the evenings, off site of the home and would include a progress note which indicated that the resident had not met their fluid goals.
The FSM indicated that they were unsure if the progress notes were reviewed or acknowledged by nursing staff.
The RD confirmed that during this process there was no observation of the residents to

assess for signs and symptoms of dehydration.
B. The "Roles and Responsibilities in Hydration Management" directive indicated that registered staff were required to review food and fluid tracking intakes and make referrals to interdisciplinary team members as needed.
The FSM indicated that previously it was the responsibility of the night registered staff to review intake records and send RD referrals when a resident did not met their fluid goals for three consecutive days; however, that this was not being completed as outlined in the policy.
The FSM indicated that they were responsible to review intake records and document in the progress notes.
The process was confirmed by the RD who reported the expectation that staff complete a Nutrition Care Referral in the assessment portion of in Point Click Care (PCC), although this was not completed.
Interviews on May 23 and 24, 2017, with RN's #118 and #110 confirmed that when a resident did not met their fluid needs, they would monitor the resident and push fluids; however, would not send a referral to the RD.
They indicated that they were unaware of how the RD was informed of residents who did not meet their hydration needs and that a referral to the RD was completed by the FSM.
C. Resident #206's plan of care indicated they had a fluid target of 1,255 milliliters (ml) per day and required set up assistance only at meal times once they were in the dining room.
Review of fluid intake records identified that for the month of March 2017, the resident was below their fluid goal 18 out of 31 days, ranging from 60 ml to 1,151 ml per day.
Progress notes during a specified time period in 2017, revealed that the resident stated they did not feel well and staff observations of the resident.
On an identified date in 2017, at the direction of the resident's SDM they were sent to the hospital for treatment.
In the Admission History note sent from the hospital on their return, the physician dictated that the "[the resident] is dehydrated" and "…will be given gentle IV infusion in order to hydrate".
Review of the clinical record did not identify that a hydration referral was sent to the RD, nor did it identify that a hydration assessment was completed by registered staff.

The procedure was not implemented. [s. 68. (2) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

A. Resident #206 returned to the home on a specified date in 2017, following a hospitalization.
On their return the physician was contacted and orders were received for medications by RN #115.
A new order was received for a medication to be administered three times a day, if needed.
A review of the clinical record did not include documentation that the resident or the Substitute Decision Maker (SDM) was informed of the new order.
Interview with RN #115 verified that they did not notify the resident /SDM of the new order.
B. A review of the clinical record identified that resident #028 had a change in condition on a specified date in 2017.
The resident was assessed by RN #115, the physician was contacted and orders were received for an antibiotic and analgesic.
RN #115 administered the analgesic with some relief shortly after it was ordered.
The clinical record did not include notification of the resident/SDM of the new orders.
Interview with RN #115 confirmed that they did not notify the resident/SDM of the changes in their plan of care.

Interview with the DOC verified the expectation that the resident and/or their SDM, when required, be notified of medication changes, specifically new medication orders and that this was not completed by RN #115.

The resident and/or SDM was not provided with an opportunity to participate in the development and implementation of the plan of care as required. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident, the SDM, if any, and the designate of the resident / SDM are provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

A. The licensee is required to have an organized program of nursing and personal support services for the home, to meet the assessed needs of residents, as identified under the LTCHA, 2007. section 8.
As part of the organized nursing and personal support services program the home had a procedure identified as LTC-Use of Oxygen Therapy, CARE12-010.10, effective date August 31, 2016.
This procedure identified that "If a resident presents with respiratory distress, based on clinical assessment, oximetry readings shall be measured. If SaO2 is less than 90%,

oxygen may be initiated. The nurse may initiate oxygen at 1 litre per minute (LPM) via nasal cannula and titrate in 1 LPM increments every 15 minutes until a SaO2 (oxygen saturation) of 90% is achieved and contact the physician/NP for orders. If you have reached 5 LPM, contact the physician /NP to notify as soon as you are able. In all circumstances of oxygen therapy, the physician/NP will be contacted within 24 hours for orders including the amount of oxygen expressed in LPM, duration and associated activity".

i. A review of the clinical record identified that on a specified date in 2017, resident #203 had a change in condition, shallow respirations at 24 breaths per minute and an oxygen (O2) saturation of 80 percent (%).
RN #114 responded to this change in condition with a number of interventions which included the administration of O2 at three LPM.
RN #110 assessed the resident a few hours later, noted shallow respirations at 30-40 breaths per minute and an O2 saturation of 88% with O2 therapy in place at three LPM.
The physician and SDM were both notified of the change in the resident's status and decline in condition prior to the resident passing away.
A review of the physician's orders did not include an order for the use of O2, which was confirmed by the DOC.
ii. The clinical record identified that on a specified date in 2017, resident #205 was declared palliative, family were aware of this change in condition and were in attendance.
Progress notes indicated that the following day at 1540 hours, the resident's respirations were 18 breaths per minute and O2 therapy was started at two LPM, by RN #116.
At 1915 hours, the resident was reassessed and had an O2 saturation at 83% with O2 in place at two LPM.
The O2 therapy was then increased to three LPM, by RN #116.
At 2216 hours, the resident was noted to be comfortable with an O2 saturation of 88% and O2 therapy at three LPM.
Progress note at 2223 hours, by RN #115, noted that O2 was maintained with nasal cannula and the resident had an O2 saturation of 89%.
The resident expired four days later, with family present.
A review of the physician's orders did not include an order for the use of O2, which was confirmed with the DOC.
Interview with RN #115 verified the use of the O2, according to their progress notes, for comfort care when the resident was palliative. The RN was not aware if the resident had an order in place for the use of the O2 at the time that it was in place.
Interview with RN #116 acknowledged awareness that the home had a procedure in place to support the use of O2 as a comfort measure without a physician's order, for

short term use; however, did not identify that the O2 was to begin at one LPM.
iii. A review of the clinical record identified that resident #206 used O2 therapy on at least three occasions in 2017.
On a specified date in 2017, the resident had a change in condition and had an O2 saturation of 81%.
RN #110 applied O2 therapy at which time the resident's oxygen saturation rose to 98%.

The resident was assessed and no congestion was noted.
On a second date in 2017, at 0424 hours, the progress note by RN #115, identified that the resident's O2 saturation was maintained at 95% with O2 therapy maintained via nasal cannula.
On a third date in 2017, at 0436 hours, the resident was assessed and was noted with an O2 saturation of 98%, when they used O2 therapy at three LPM using nasal prongs.
An RT Respiratory Services Inc, Clinical Outcome Report, identified that they were called to complete an O2 assessment of the resident, as they were using O2 therapy.
The report identified that the resident did not use the O2 at the time of the assessment, reportedly had not needed the therapy recently and the equipment was left at the bedside despite the fact that they did not qualify for funding.
A second RT Respiratory Services Inc, Clinical Outcome Report, was completed late in 2017, for another O2 assessment.
The resident did not use O2 therapy at the time of the assessment and was not in respiratory distress.
The resident denied use of the therapy recently and the equipment was removed from the bedside as they did not qualify for funding.
A review of the clinical record did not include an order for O2 therapy as confirmed by the DOC.
Interview with RN #110 did not recall the resident to have an order for the use of O2 therapy; however, was aware of the procedure which allowed the use O2 therapy on residents, when in distress and identified that when this procedure was used the therapy would be initiated, based on resident's need, at a low rate of one and a half to two LPM.
Interview with RN #115 verified awareness of the procedure which allowed the use O2 therapy on residents, to promote comfort when in distress and identified that the therapy would be initiated at a rate of two LPM.

The procedure for the use of O2 therapy was not complied with.

B. Ont. Reg. 79/10 s. 48(1) requires the home to have a pain management program to identify pain in residents and manage pain.

The home had a procedure on Pain Assessment and Management - LTC - Pain Assessment, CARE8-O10.01, effective date August 31, 2016, which identified that "resident will be screened for pain: move in, new or worsened pain (which may be identified by resident/SDM, family or UCP, etc), with a change in condition (i.e. post fall, confirmed fracture). The nurse will screen for pain by asking the resident verbally if they have pain, or by observing them for signs of pain. If resident answers yes, or shows signs of observed pain, the nurse will assess for pain using Pain Assessment Tool and Initiate a 72-Hour Pain Monitoring Tool".

The home had a procedure on Pain Assessment and Management - LTC - Pain Interventions and Monitoring, CARE8-O10.02, effective date August 31, 2016, which identified to "initiate pain monitoring: on move in, new or worsened pain pain (which may be identified by resident/SDM, or Unregulated Care Provider (UCP) etc), with a change in condition (i.e. post fall, confirmed fracture), new regular pain medication is ordered, dosage increase or decrease of regular pain medication, pain medication is discontinued, PRN pain medication is used for three consecutive days, breakthrough pain (BTP) medication is used for three consecutive days".

i. A review of the clinical record identified that resident #208 had symptoms of pain and on a specified date in 2017, the physician ordered an as needed narcotic analgesic.
The resident was monitored on various shifts over a six day period of time, utilizing a Pain Monitoring Sheet, which noted denial of pain and on one occasion reported pain; however, refused analgesic.
Progress notes identified that the resident did not use the analgesic and it was discontinued.
RN #115 processed the physician's orders to discontinue the use of the analgesic on the identified date and verified that they did not complete or initiate a Pain Assessment or Monitoring Tool when the order was received.
Later that same month the resident reported pain, was administered an over the counter analgesic, with effect, as recorded in the progress notes.
Following the use of the over the counter analgesic RN #115 contacted the physician due to the resident's reports of pain.
The physician re-ordered the use of the narcotic analgesic.
The RN verified that they did not complete or initiate a Pain Assessment or Monitoring Tool at the time that the order was received and processed.
According to the electronic Medication Administration Records (eMAR) for a two month period of time in 2017, the resident was administered the narcotic analgesic on three

consecutive days, each time with effect.
RN #115 was the nurse who administered the third dosage, in as many days, of the as needed analgesic. When interviewed it was verified that a they had no recall of initiating or completing a Pain Monitoring Tool at that time.
The physician reassessed the resident at which time routine analgesic was ordered to promote comfort.
Following ongoing use of the routine analgesic the resident was again reassessed and the physician ordered an increase in the routine analgesic.
A review of the clinical record did not include a Pain Assessment Tool completed for the resident, as confirmed following a clinical record review by the DOC.
The resident had Pain Monitoring Sheets completed for each time period when they had a change in analgesic as verified by the DOC.
ii. Resident #206 had a history of chronic pain which was identified in their plan of care with interventions to manage.
A review of the clinical record identified that the resident utilized narcotic analgesics as a strategy to manage the pain.
The progress notes identified, a representative of the resident requested to speak with the physician in 2017, to discontinue the use of a narcotic due to symptoms observed.
The physician spoke with the representative the following day.
According to the eMAR the resident had their dosage of their routine narcotic reduced the next day and it was replaced with an as needed dosage.
The DOC, following a review of the clinical record, was not able to provide a completed Pain Assessment or Monitoring tool for this time period, to evaluate the effectiveness of this change.
According to the eMAR the usage of the as needed analgesic increased the following month.
In response to this change in need orders were received to increase the dosage of the as needed narcotic analgesic and the dosage of a routine over the counter analgesic seven days later.
The DOC, following a review of the clinical record, was not able to provide a completed Pain Assessment or Monitoring tool for this time period, to evaluate the effectiveness of this change.

Staff did not comply with the procedure as required. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's health condition.

Resident #206 was admitted to the home in 2016.
Multiple progress notes identified that the resident experienced heartburn on occasion.
On a specified date in 2017, the resident was admitted to the hospital with unusual symptoms.
A review of the clinical record identified a consultation note received by the home that same month, which identified that the resident had a specific diagnosis and surgery as a result.
The RD, who began to work at the home, following this return from hospital, in April 2017, recorded on progress note on April 20, 2017, which identified "during review of chart to look for hospital noted diagnostic test which revealed the previous diagnosis and surgery as well as how this would impact the resident.
A review of the document that the home referred to as the care plan did not include the surgery until it was identified by the RD on April 20, 2017 and not at the time of the consult note earlier in 2017, which was confirmed by the FSM on May 23, 2017.
As of May 24, 2017, there was no identification of the surgery in the resident's medical diagnosis summary of their health record.

The home did not ensure that the plan of care was based on an interdisciplinary assessment of all of resident's health condition. [s. 26. (3) 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 the plan of care is based on an interdisciplinary assessment of the resident's health condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Review of resident #209's health record identified a daily fluid target of 1,975 milliliters (ml) per day.
The fluid intake record revealed that from May 7 to 22, 2017, the resident did not meet their fluid goals on any of the 14 days, with intake ranging from 375 ml to 1,565 ml.
The clinical record did not identify any RD referrals or any hydration assessments.
Interview with the RD on May 23, 2017, confirmed that they had not received any hydration referrals for this resident.
On May 24, 2017, the RD identified that RN #110 indicated that the resident received an extra 500 ml of fluid each day during medication administration, as they consumed a full glass of liquid each time they took their medication, but staff did not document these additional fluids for the resident or any other resident.
Interview with RPN's #121, #122 and #123 on May 24, 2017, confirmed that the fluids that residents consumed during the administration of medications were not documented by registered staff for any residents in the home.
The RD confirmed that the food and fluid intake records completed by the PSW's did not capture each resident's total daily fluid intake, which was used to assess if the residents met their hydration needs.

The home did not ensure action taken with respect to a resident was consistently documented. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #207 had a focus statement in their plan of care which identified chronic pain.
In 2017, the resident was admitted to the hospital for assessment and returned later that month.
The resident was ordered a narcotic analgesic on return from the hospital to be administered on a routine basis.
The resident had ongoing verbal reports of pain.
The resident was assessed by the physician the following month, at which time the dosage of the narcotic analgesic was increased.
Interview with RN #115, who was one of the two registered staff who processed the medication order for the increase in narcotic analgesic, verified that they did not initiate or completed a pain assessment, using a clinically appropriate assessment instrument.
A review of the clinical record did not include a completed clinically appropriate pain assessment, for the resident during the identified time period, when interventions in place were not effective, as confirmed during a record review by the DOC. [s. 52. (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 when a resident's pain was not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #206 was at risk for impaired skin integrity as identified on their plan of care. The resident was admitted to the hospital in 2017 and was readmitted back to the home eleven days later.
A review of the clinical did not include a head to toe assessment when the resident returned to the home, as confirmed by RN #110 following a review of the clinical record. [s. 50. (2) (a) (ii)]

Issued on this 21st day of June, 2017

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2017_556168_0014
Log No. / Registre no:	007448-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 12, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	DOVER CLIFFS 501 St George Street, P.O. BOX 430, Port Dover, ON, N0A-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pauline Robinson

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 shall implement their policy "LTC – Food and Fluid Intake Monitoring", CARE7-0.10.02, and the corresponding document "Roles and Responsibilities in Hydration Management" to ensure that residents who consume less than their minimal recommended fluid intake for three consecutive days are, at a minimum, provided with the following in a timely fashion:
-identified by a review of food and fluid intake records;
-are assessed/evaluated to determine if they show signs and symptoms of dehydration, and that this assessment/evaluation is documented and action is taken if appropriate;
-that there is a referral to the registered dietitian for an assessment, analysis and/or revisions to the plan of care, when clinically appropriate; and
-that the plan of care is implemented and evaluated as appropriate.

Grounds / Motifs :

1. Application of the Judgement Matrix:

Severity - Level 2 - Minimal harm or potential for actual harm
Scope - Level 3 - Widespread
Compliance history - Level 4 - Ongoing non-compliance despite previous action taken by the Ministry. A previous related non-compliance was identified during the 2015 RQI inspection - O Reg 79/10 section 68(2)(e) as a VPC.

The licensee failed to ensure that the policies and procedures relating to nutrition care and dietary services and hydration were implemented.

The home's policy Food and Fluid Intake Monitoring, CARE7-0.10.02, last revised July 31, 2016, identified that when a resident drank less than their minimal recommended beverage intake for three consecutive days, staff were to assess if the resident showed signs and symptoms of dehydration. If yes, a nutrition care referral was to be sent to the RD and if not, "based on nursing clinical judgment, determine whether or not a Nutrition Care Referral to the RD is required".

A. On May 23, 2017, the FSM indicated that it was currently their responsibility to review fluid intake records of residents on a weekly basis.
This task would often be completed in the evenings, off site of the home and would include a progress note which indicated that the resident had not met their fluid goals.
The FSM indicated that they were unsure if the progress notes were reviewed or acknowledged by nursing staff.
The RD confirmed that during this process there was no observation of the residents to assess for signs and symptoms of dehydration.
B. The "Roles and Responsibilities in Hydration Management" directive indicated that registered staff were required to review food and fluid tracking intakes and make referrals to interdisciplinary team members as needed.
The FSM indicated that previously it was the responsibility of the night registered staff to review intake records and send RD referrals when a resident did not met their fluid goals for three consecutive days; however, that this was not being completed as outlined in the policy.
The FSM indicated that they were responsible to review intake records and document in the progress notes.
The process was confirmed by the RD who reported the expectation that staff complete a Nutrition Care Referral in the assessment portion of in Point Click Care (PCC), although this was not completed.
Interviews on May 23 and 24, 2017, with RN's #118 and #110 confirmed that

when a resident did not met their fluid needs, they would monitor the resident and push fluids; however, would not send a referral to the RD.
They indicated that they were unaware of how the RD was informed of residents who did not meet their hydration needs and that a referral to the RD was completed by the FSM.
C. Resident #206's plan of care indicated they had a fluid target of 1,255 milliliters (ml) per day and required set up assistance only at meal times once they were in the dining room.
Review of fluid intake records identified that for the month of March 2017, the resident was below their fluid goal 18 out of 31 days, ranging from 60 ml to 1,151 ml per day.
Progress notes during a specified time period in 2017, revealed that the resident stated they did not feel well and staff observations of the resident.
On an identified date in 2017, at the direction of the resident's SDM they were sent to the hospital for treatment.
In the Admission History note sent from the hospital on their return, the physician dictated that the "[the resident] is dehydrated" and "…will be given gentle IV infusion in order to hydrate".
Review of the clinical record did not identify that a hydration referral was sent to the RD, nor did it identify that a hydration assessment was completed by registered staff.

The procedure was not implemented. [s. 68. (2) (a)] (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 12th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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