Ministry of Health and Long-Term Care

Ministére de la Santé et 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE WARRENER (107), DEBORA SAVILLE (192), GILLIAN HUNTER (130), TAMMY SZYMANOWSKI (165), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2012_066107_0008
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	May 1, 2, 3, 4, 8, 9, 10, 11, 14, 15, 16, 17, 18, 22, 23, 24, 25, 28, 29, 30, 31, Jul 3, 4, 5, 6, 9, 10, 11, 12, 13, 27, 30, 31, Aug 1, 9, 16, 20, 21, 22, 23, 24, 2012
Licensee / Titulaire de permis :	GRACE VILLA LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	GRACE VILLA NURSING HOME 45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~LYNETTE TYLER~~ Wendy Hall

To GRACE VILLA LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2011_065169_0015, CO #001

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

Order / Ordre :

The licensee shall immediately complete an initial plan of care for an identified resident, based on completed assessments and the assessment, reassessments and information provided by the placement co-ordinator under section 44, and shall make the plan of care available to front line staff.

Grounds / Motifs :

1. The licensee failed to ensure that when a resident is admitted to the long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44.

a) An identified resident was admitted to the home and a care plan created related to dietary needs was created for the resident by the dietitian the next day. No initial plan of care related to the activities of daily living or other care needs existed for the identified resident four days later. Staff interviewed confirmed that the plan of care is to be initiated at the time of admission and a Kardex is to be printed for access by the front line staff. No Kardex was available for front line staff related to the care needs of the resident. The registered nurse responsible for the resident's care confirmed that no plan of care had been initiated for the resident. (192)

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

---

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2011_066107_0002, CO #004

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan that outlines how the home will ensure that the care set out in the plan of care for all residents related to nutritional care, meal and snack services, falls, and infection control, will be provided to the residents as specified in their plans. The plan shall include monitoring, analysis and evaluation activities.
The plan is to be submitted by September 18, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail Michelle.Warrener@ontario.ca or Fax 905-546-8255.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued under the Nursing Homes Act June 8, 2010 under s. 20.10; Previously issued as s. 6(7) on September 7, 2010 as a CO; November 3, 2010 as a VPC; May 24, 2011 as a CO; September 12, 2011 as a CO.
The licensee failed to ensure that care set out in the plan of care was provided to residents as specified in their plans:
a) An identified resident's plan of care indicated that they had an infection and direction was provided for staff to use universal precautions and to wear gloves during care. It was noted that swabs of the resident's wounds were positive for the infection on two occasions. Registered staff and Personal Support Workers interviewed were unclear of the resident's infection status. Signage and personal protective equipment (PPE) were not available for staff use while providing care. Personal Support Workers were observed providing personal care without the use of PPE. Care was not provided as specified in the resident's plan of care.
b) The licensee did not ensure that the care set out in the plan of care for two identified residents, in relation to falls, was provided as specified in their plans of care.
i) The plan of care for an identified resident indicated they were at high risk for falls and staff were to ensure their bed was in the lowest position when in bed. Staff interviewed reported that the resident had two full bed rails raised when they were in bed because they would attempt to climb out. On May 15, 2012, the resident was observed in bed with two full padded rails raised; the bed was not in the lowest position. Staff confirmed the bed was not in the lowest position on this date.
ii) The plan of care for an identified resident indicated the resident was a high risk for falls and directed staff to ensure that both rails were raised and to ensure the bed was in the lowest position at all times when in bed. The bed was not in a low position and staff interviewed confirmed the bed was not in its lowest position. The plan also directed staff to ensure that a chair alarm was insitu whenever the resident was in their chair. The resident was observed in their chair on at least two occasions, May 11 and 14th, 2012, without a chair alarm in place. Staff interviewed confirmed the resident never had a chair alarm in place, despite the direction in the plan of care. (130) (130)
2. The licensee did not ensure that the care set out in the plan of care for the following residents, in relation to meals and snack service, was provided as specified in their plans:

At the observed afternoon snack pass May 14, 2012:
a) Four residents received an incorrect texture of snack, creating a risk for choking or an unnecessary downgrade in texture:
i) An identified resident was provided with a pureed textured snack, however, their ordered diet texture was minced. A minced textured snack was not offered.
ii) An identified resident had a diet order for a regular textured diet with pureed meats, however, they were given a pureed textured snack. The resident did not ask for the texture downgrade and a regular cookie was not offered.
iii) An identified resident required a pureed texture, however, was given regular textured cookies.
iv) An identified resident had an order for regular with minced meat texture, however, was provided with a pureed snack. The resident did not request the downgrade in texture.
b) Two residents received the incorrect texture of thickened fluids, creating a risk for aspiration or a decrease in available free fluids:
i) An identified resident required honey thickened fluids, however, thin water was left at the resident's bedside.

Staff confirmed the resident was not to have thin water.
ii) An identified resident had an order for nectar thickened fluids, however, was served honey thickened fluids.
c) residents requiring a regular diet or a diet with high energy interventions were provided diet beverages which was not consistent with their plans of care. The residents did not request the diet beverages. (107)

At the observed lunch meal May 2, 2012:
a) Four identified residents had a plan of care for High Energy High Protein diets with homo milk, however, the milk was not provided/offered.(107)

During the lunch meal May 17, 2012:
a) Five identified residents received fluids that were not consistent with their plans of care.
b) An identified resident did not receive direction identifying the location of their food on their plate using the 12 hour clock (as per the plan of care). (165)

At the observed breakfast meal May 18, 2012:
a) One resident received the incorrect texture of meal, creating a risk for choking. The identified resident had a plan of care for a pureed texture diet, however, the resident was given a minced textured diet. Staff interview confirmed that the resident required a pureed textured meal and the minced texture was provided in error.
b) Three residents received the incorrect consistency of fluids creating a risk for aspiration due to under thickening, or a reduction in the amount of free fluids due to over-thickening:
i) An identified resident's plan of care stated nectar consistency thickened fluids, however, thin water was provided along with thickened fluids.
ii) An identified resident's plan of care stated nectar consistency thickened fluids, however, they were provided thin milk. The milk was removed when the inspector questioned the consistency, however, a replacement of thickened milk was not offered.
iii) An identified resident required honey thickened fluids, however, was provided nectar thick juice, and thin milk mixed with their hot cereal (very thin and mixed consistency).
c) Three observed residents' plans of care stated to provide 175ml homogenized milk with meals (high energy high protein plan of care), however, it was not provided. One of the residents was provided tray service, however, the milk was not included in the tray service.
d) Six observed residents' plans of care stated to provide probiotic yogurt at the breakfast meal, however, it was not offered.
e) Three observed residents' plans of care stated to provide a banana at the breakfast meal, however, it was not available (as per staff interview) and not provided to the residents.
f) Three observed residents' plans of care stated to provide high fibre interventions (prunes, prune juice, fruit lax, etc), however, they were not provided.
g) Two observed residents received care that was not consistent with the care identified on their plans:
i) An identified resident had a dislike of fruit lax noted on their plan of care. The resident was provided with fruit lax, however, did not consume it.
ii) An identified resident had a plan of care to provide a special item at breakfast, however the item was not available nor offered to the resident.

Please note: this evidence of non-compliance is also related to complaint #H-000900-12/H-000615-12 report 2012_066107_009 / H-000094-12. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Order # /
Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2011_066107_0002, CO #002

Pursuant to / Aux termes de :

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

Order / Ordre :

Section 153(1)(a)
The licensee shall ensure that residents are reassessed and the plan of care reviewed and revised at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; and (c) care set out in the plan has not been effective. This includes four identified residents in relation to hydration and weight loss, one identified resident in relation to continence, one identified resident in relation to falls risk, two identified residents related to responsive behaviours, and one identified resident in relation to treatments.

Section 153(1)(b)
The licensee must prepare, submit and implement a plan that outlines how the home will ensure that residents are reassessed and their plan of care reviewed and revised at any other time when, (b) the resident's care needs change or the care set out in the plan is no longer necessary and (c) care set out in the plan has not been effective. The plan shall include training/education to registered staff (Registered Nurse, Registered Practical Nurse, Registered Dietitian) in relation to the identification and assessment of resident changes in condition, and the evaluation of the effectiveness of the plan of care.

The plan is to be submitted by September 18, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail Michelle.Warrener@ontario.ca or Fax 905-546-8255.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)] Previously issued under the Nursing Home Act section 20.10 related to un-met criteria B2.4 and B1.6 January 7, 2010; Previously issued as s. 6(10)(b) on November 3, 2010 as a VPC; February 1, 2011 as a CO; May 24, 2011 as a CO for both (b)(c).
The licensee did not ensure that residents were reassessed and their plans of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.
a) An identified resident was not reassessed and their plan of care reviewed and revised when their care needs changed. The resident returned from hospital after receiving intravenous (IV) fluids for dehydration. The registered dietitian confirmed that there was no reassessment completed and the plan of care was not reviewed and revised related to the resident's hydration status despite the resident returning to the home with a diagnosis of dehydration. (165)
b) An identified resident did not have their plan of care revised when the resident went from occasionally incontinent to totally incontinent of bowels. The bowel and bladder continence assessment was the same as on the previous assessment, however, the resident's care needs had changed. PSW staff interview confirmed the resident had a change in their level of continence. The plan of care was not revised related to the change in continence. (107)
c) The plan of care for an identified resident was not revised when their care needs changed and the care set out in the plan was no longer necessary. The plan of care indicated the resident required an assistive device for mobility and staff were to ensure that they were supervised and that there were no tripping hazards in the

immediate area. The plan indicated the resident had an extensive history of falls; staff were to remind the resident to use the mobility device as they often forgot; to ensure the resident wore proper footwear as had been the cause of previous fall(s); and to ensure the resident was not using the assistive device improperly. According to staff interviewed the resident's assistive device was removed from the home for the resident's safety as they had been wheelchair dependent for the last four months. Staff reported the resident was no longer able to ambulate independently with assistive devices. (130)
d) An identified resident had a physician order for a wound treatment, however, the order was later discontinued. The plan of care in effect on May 25, 2012 included direction to staff to apply the treatment and was not updated with this change in treatment. Discussion with the Assistant Director of Care and registered staff confirmed that the plan of care was not updated with this change at the time the plan of care was reviewed following readmission from hospital. (192)

[LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(c)]
The licensee did not ensure that residents were reassessed and their plans of care reviewed and revised at least every six months and at any other time when, the care set out in the plan was not effective.
a) An identified resident's plan of care was not revised when it was not effective. A physician's note indicated that the resident's lab values indicated dehydration and staff were to continue to encourage fluids. Physician assistant notes dated 3, 5, 6, and 9, months after the first note required staff to push fluids. The dietitian indicated (1 month after the first note) that the resident's consumption dropped below their daily fluid recommendation and by four months after the first note the resident's fluid consumption was only 68% of their daily recommendation. The resident's fluid consumption remained poor and the dietitian completed reassessments, however, there was no action taken and the plan of care was not revised when the care set out in the plan had not been effective in meeting the resident's hydration needs. A treatment for re-hydration was initiated 9 months after the first note by the home's Physician.
b) An identified resident had a significant weight loss of 3.3kg in one month dropping 7.9kg below their established goal weight range. The resident was receiving supplementation several times a day. The dietitian assessment indicated that the resident was functionally declining resulting in decreased intake and weight. The resident continued to experience weight loss and a significant weight loss of 10.8%, however, the plan of care was not revised to address the ongoing weight loss.(165)
(PLEASE NOTE: This evidence of non-compliance was found during inspection #2012_066107_009/H-000094-12)
c) The licensee did not ensure that an identified resident was reassessed and the plan of care reviewed and revised when the care set out in their plan had not been effective. A personal support worker confirmed that the resident had dry, cracked lips and that the resident consumed less than one glass of fluid per meal. The home's dietitian confirmed that the resident did not meet their daily hydration requirements, however, the resident was not reassessed and the plan of care was not reviewed and revised when the care set out in the plan was not effective in relation to hydration. (165)
d) The licensee did not ensure that an identified resident was reassessed and their plan of care revised when the plan was ineffective in relation to hydration. The home's dietitian confirmed that supplementation was initiated, however, there was no evaluation of the intervention's effectiveness despite resident refusal of the supplement 32/62 times in one month; 45/60 times the next month and 25/35 times the subsequent month. The dietitian indicated in the resident's clinical record that the resident's fluid intake was not meeting their fluid recommendations, however, the dietitian confirmed that action was not taken and interventions were not revised on the plan of care related to the resident's hydration status. (165)
e) The plan of care related to responsive behaviours was not revised for an identified resident, despite repeated recorded incidents of verbal and physical aggression and complaints of fear from co-residents. Staff interviewed confirmed the staff were aware of the incidents and concerns expressed by co-residents, however, the planned interventions were not revised.(130)
f) The plan of care for an identified resident related to responsive behaviours was not revised despite repeated recorded incidents of physical aggression towards co-residents and staff. The planned interventions remained the same, despite being ineffective and the plan of care related to responsive behaviours was not revised. (130)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2011_066107_0002, CO #003

Pursuant to / Aux termes de :

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

Order / Ordre :

Section 153(1)(a): The licensee shall ensure that an identified resident is reassessed and their plan of care reviewed and revised in relation to weight loss, and the licensee shall ensure that different approaches are considered in the revision of the plan of care related to weight loss.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(11)(b)] Previously issued May 24, 2011 as a CO.
The licensee did not ensure that when residents were reassessed and their plan of care revised because the care set out in the plan was not effective, different approaches were considered in the revision of the plan of care.
An identified resident was reassessed on two occasions by the home's dietitian and the plan of care was revised because care set out in the plan of care was not effective in relation to continued weight loss, however, alternate strategies were not considered in the revision of the plan of care. The home's dietitian initiated a supplement for the resident on admission and increased the supplement on two occasions, however, the dietitian confirmed that alternate strategies, including the utilization of food, were not considered in the revision of the plan of care. Staff confirmed that the resident had a good appetite but was constantly active. The resident had lost 11.6% of their body weight and continued to have gradual weight loss. (165)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2012

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant:

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8,
s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Order / Ordre :

The licensee shall ensure there is an organized program of hydration for the home to meet the hydration needs of the residents. The licensee must ensure the hydration program includes:
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 hydration; b) the identification of any risks related to hydration; c) the implementation of interventions to mitigate and manage those risks; and d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 11(1)(b)] Previously issued as un-met criterion B3.25 January 7, 2010 and B3.29 May 18, 2010 under the Long Term Care Homes Program Manual; Previously issued as s. 68(2)(d) May 24, 2011 as a VPC.
The licensee of the long term care home did not ensure there was an organized program of hydration for the home to meet the hydration needs of residents.
a) The home's dietitian confirmed that the hydration assessment and management policy (effective date January 2012) was not implemented and that the policy did not meet the hydration needs of all residents. The policy indicated that staff were to refer to the dietitian if a resident had less than 750ml/day for 3 days however, the dietitian indicated that it would not meet the hydration needs of all residents (example: one resident required 3375ml/day and a referral to the dietitian would not occur until the resident was consuming 22% of their fluid requirement).
b) The nutrition and hydration program did not include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. Registered staff interviewed, and the home's dietitian, confirmed that they do not monitor or evaluate the resident's food and fluid intake records for residents with identified risk related to nutrition and hydration. Registered staff indicated they only become aware of residents with compromised intake if personal support workers report that a resident has eaten poorly for that meal, however, they do not review residents' intake records. The home's dietitian confirmed that the FSM, the FSS, and the dietitian did not monitor and evaluate the food and fluid intake records of residents with identified risks related to nutrition and hydration until the residents' quarterly assessments or a referral for poor oral intake was received. One example: An identified resident was deemed high nutritional risk, had fluid intake from 500-625ml/day, for three consecutive days however, there was no system in place to monitor the resident's decreased fluid intake and there was no evaluation completed of the resident's decreased fluid consumption. The dietitian confirmed that the resident was not meeting their fluid requirement of over 1000ml/day. (165)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2011_066107_0002, CO #010

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

Section 153(1)(a):
The licensee must ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Section 153(1)(b):
The licensee must prepare, submit and implement a plan that includes:
a) education for Registered staff related to weekly wound assessments
b) a system to monitor, analyze, and evaluate the completion of weekly wound assessments
The plan is to be submitted by September 18, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail Michelle.Warrener@ontario.ca or Fax 905-546-8255.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 50(2)(b)(iv)] Previously issued September 7, 2010 as a VPC and CO; issued May 24, 2011 as a CO.
The licensee of the long term care home did not ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
The licensee of the long term care home did not ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
a) An identified resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds was not reassessed at least weekly by a member of the registered nursing staff. The registered practical nurse (RPN) confirmed that the resident acquired several staged pressure ulcers on several areas of the body and a skin tear. There were no weekly wound assessments completed for one of the wounds over a four week span. There were no weekly wound assessments completed for another of the wounds over a two week span. There were no weekly wound assessments for the skin tear completed over a three week span. The RPN confirmed that these weekly assessments were not completed and that a weekly wound assessment initiated for two of the wound areas was initiated however not completed. (165)
(PLEASE NOTE: This evidence of non-compliance was found during inspection #2012_066107_009/H-000094-12)
b) Registered staff confirmed that an identified resident sustained a skin tear and treatment was ordered with a required weekly wound assessment. The registered practical nurse confirmed that there was no weekly wound assessment completed and was unable to produce a completed wound assessment for over a three week time period. (165)
c) An identified resident had multiple staged wounds on various areas of their body. Interview confirmed that assessments of each of these wound areas were to be completed weekly and documented in Point Click Care. A review of documentation over a two month period confirmed that assessments were not consistently completed weekly on each of these wounds by a member of the registered staff. There were no documented assessments of one area over a three week and a 2.5 week period. No documented assessment of another area over a two week and a four week period and no documented assessment of another area over a 3.5 week and a one month period.
During the two month period, the resident had an infection in their wounds and on return from hospital a head to toe assessment indicated that the resident had multiple staged wounds. Weekly assessment of the resident's stageable wounds was not consistently completed.(192) (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

Order # /
Ordre no : 006

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

Linked to Existing Order /
Lien vers ordre existant: 2011_066107_0002, CO #005

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee must prepare, submit and implement a plan that outlines how the home will ensure that:
a) residents are weighed at minimum monthly and when there are significant changes, those changes are verified by a re-weigh (as per the home's policy)
b) residents with significant weight changes are assessed by the multidisciplinary staff, including the Registered Dietitian
c) action is taken and outcomes are evaluated for effectiveness to address the weight changes
d) education for staff related to the home's policy "Monitoring Resident's Weight and Height".
The plan is to be submitted by September 18, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail Michelle.Warrener@ontario.ca or Fax 905-546-8255.

Grounds / Motifs :

1. 1. [O.Reg. 79/10, s. 69.4] Previously issued as un-met criterion B3.24 under the Long Term Care Homes Program Manual January 7, 2010; Previously issued as s. 69 May 24, 2011 as a CO.
The licensee did not ensure that residents with the following weight changes were assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated: 4. Any other weight change that compromises their health status.
An identified resident had continued with gradual weight loss over a one year period, losing 9.9% of their body weight and remaining below their established goal weight range since the previous year. The resident had three quarterly nutritional reviews completed during this time however, no action was taken and outcomes were not evaluated to address the resident's continued weight loss. It was not until the family requested the resident be seen by the home's dietitian that any action was taken despite the resident's weight which decreased 6.4 kg and remained below their goal weight range.
2. [O.Reg. 79/10, s. 69.1]
The licensee did not ensure that residents with the following weight changes were assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated: 1. A change of 5 per cent of body weight, or more, over one month.
The licensee did not ensure that actions were taken and outcomes evaluated when an identified resident had a significant weight gain (10kg) documented over a one month period. The home's registered dietitian queried the accuracy of the weight and requested a re-weigh of the resident as soon as possible, and for registered staff to enter the new weight into point click care (PCC). Two days later the dietitian again requested that a reweigh be obtained and entered into PCC. The dietitian confirmed that when a reweigh had been taken it would be entered into PCC and an evaluation would be documented in the progress notes however, the reweigh for the resident was not taken and recorded in PCC by staff and therefore outcomes were not evaluated. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Order # / Ordre no : 007 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2011_066107_0002, CO #007

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 prepare, submit and implement a plan that outlines how the home will ensure that:
a) foods are not prepared and hot held too far in advance of meal service
b) the same level of quality is provided for items being prepared for the minced and pureed textured menus
c) recipes are followed in the preparation of menu items to ensure consistency of texture, nutrient density and flavour
d) texture modified foods are not mixed together without the consent of residents
e) the menu is reviewed to include an appropriate side dish for all menu days
f) desserts are stored in a manner that ensures food quality and appearance are preserved
The plan is to be submitted by September 18, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail Michelle.Warrener@ontario.ca or Fax 905-546-8255.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 72(3)(a)] Previously issued September 7, 2010 as a CO and May 24, 2011 as a CO.
Not all food was prepared and served using methods that preserved taste, nutritive value, appearance and food quality at the lunch and dinner meals.
a) Menu items were cooked too far in advance of meal service resulting in reduced nutritive value and food quality. Staff preparing the dinner meal May 22, 2012 started cooking the minced and pureed cauliflower and the potatoes at 1230 hours for the dinner meal at 1715 hours. The items were placed in hot holding from 1330 until after the dinner meal (over 4 hours). The minced beef stew was placed into hot holding at 1447 for the supper meal May 22, 2012. The Food Service Manager confirmed that the foods were cooked too far in advance of meal service. The Home's policy B.4 related to food production stated that the Nutrition Manager ensured that hot foods were produced so that the time from the completion of preparation to the time of the beginning of service did not exceed one hour. Recipes stated foods should not be hot held for longer than four hours. Food Committee meeting minutes in April 2012 reflect residents had concerns about overcooked food.
b) Items served for the texture modified menus did not preserve the same level of quality as items for the regular menu. Peameal bacon, prepared for the texture modified menu for the breakfast meal May 23, 2012 was cooked a day in advance (afternoon of May 22, 2012). The item was cooked, cooled and then would be reheated for the breakfast meal the next day, resulting in reduced quality for the pureed texture meal.
c) Cooking water was added to the cauliflower while it was being pureed for the dinner meal May 22, 2012, resulting in a runny texture requiring the addition of thickener. The recipe did not contain thickener. The taste, nutritive value, and quality of the cauliflower were not preserved.
d) At the lunch meal May 22, 2012 pureed texture menu items were mixed together without the consent of a resident being assisted with eating. Staff was observed mixing pureed quiche, mashed potatoes and mixed vegetables while feeding the resident. Staff interview confirmed that the resident had not requested their food be mixed together.
e) Some meals were not planned to preserve appearance and food quality. A side dish was not planned with the lunch meal Week 1 Friday. The hot dog and cheese was planned with a condiment sized portion of tomato and onions (60ml) and not a full side dish.
f) Desserts were stored and served on carts that had been sitting at room temperature for over 1 hour which did not preserve the taste and quality of the chocolate mousse with topping at the lunch meal May 2, 2012. No rationale was provided for the items being different than those on the planned menu.
Please note: this evidence of non-compliance is also related to complaint #H-000900-12/H-000615-12 report 2012_066107_009 / H-000094-12. (107)

Ministry of Health and Long-Term Care

Ministére de la Santé et 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 : Oct 31, 2012

Order # / Ordre no : 008 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2011_066107_0002, CO #008

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan that outlines how the home will ensure that:
a) residents are provided with eating aids and assistive devices at meals and snacks
b) residents are provided with any personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible at meals and snacks
The plan shall include a system to monitor, analyze, and evaluate the provision of assistance and assistive devices at meals and snacks and proper techniques to assist residents with eating.
The plan is to be submitted by September 18, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail Michelle.Warrener@ontario.ca or Fax 905-546-8255.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 73(1)9] Previously issued January 7, 2010 under the Long Term Care Homes Manual as un-met criterion B3.32; Previously issued as s. 73(1)9 May 24, 2011 as a CO.
Not all residents were provided with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
a) Two identified residents who required assistance with eating were not provided with the required assistance during lunch meals May 2 and May 17, 2012. The residents did not eat well without the assistance. (165)
b) Assistive devices (nosey cups, 2 handled mugs, mugs with lids) were not available on the snack cart and the devices were not provided to the residents who required them at all snack passes observed:
The morning snack pass May 25, 2012 on two floors:
i) An identified resident required an assistive device, however, this was not provided to the resident. Staff stated the resident spilled beverages on themselves and staff had to stay with the resident while they drank without using the assistive device. The resident would be more independent with the required assistive device.
ii) An identified resident required an assistive device for beverages, however, this was not provided to the resident. Staff had to provide assistance to the resident, however, the resident would be independent with use of the assistive device.
iii) Staff interview confirmed that assistive devices were not consistently provided on the snack carts.
iv) Assistive devices were not available on another snack cart and staff stated that there were no residents who required assistive devices for beverages. Diet lists identified that two residents required assistive devices on that floor; these were not available.

At the afternoon snack pass May 14, 2012:
i) Two identified residents required assistive devices, however, these were not provided to the residents as indicated in their plans of care.
ii) Assistive devices were not placed on the snack cart and available for residents.

At the breakfast meal May 18, 2012:
i) Two identified residents did not receive assistive devices as per their plan of care. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

Order # /
Ordre no : 009

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

Linked to Existing Order /
Lien vers ordre existant:

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan that outlines how the home will ensure that staff and others involved in the different aspects of care of all residents collaborate with each other in the assessment of continence care and falls risk management to ensure that their assessments are integrated, consistent with, and complement each other.
The plan is to be submitted by September 18, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail Michelle.Warrener@ontario.ca or Fax 905-546-8255.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(a)] Previously issued September 7, 2010 as a VPC; September 12, 2011 as a WN.
Staff involved in the different aspects of care did not collaborate with each other in the assessment of residents so that their assessments were integrated, consistent with and complemented each other.
a) Staff completing assessments of an identified resident did not collaborate with each other in the assessment of the resident so their assessments were consistent and complemented each other. Nursing progress notes, falls assessments, and progress notes for bowel and bladder continence assessments contained conflicting information during the same time period. Nursing progress notes stated the resident was incontinent of loose stool. The bowel and bladder assessment stated the resident was continent of bowels. The falls risk assessment summary stated the resident had been continent and in complete control of bowel and bladder in the previous 14 days.
Another bowel and bladder assessment stated the resident was both continent and incontinent of bladder, however, the falls risk assessment summary stated the resident was continent of urine and in complete control. (107)
b) Staff involved in the different aspects of care did not collaborate with each other in the assessment of an identified resident so that their assessments were integrated, consistent with and complemented each other. Falls risk assessments and bowel and bladder continence assessments contained conflicting information, even when completed on the same day by different staff members.
Progress notes of the bowel and bladder assessment stated the resident was incontinent and wore an incontinent product, however, the falls assessment completed on the same date stated the resident was continent and in complete control of both bowel and bladder.
Another bowel and bladder assessment in the progress notes stated the resident was continent of bowels and both continent and incontinent of bladder, however, the falls assessment of the same date stated the resident was incontinent of bowels once a week and incontinent of bladder twice a week. (107)
c) The licensee did not ensure that staff and others involved in the different aspects of care of an identified resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. A fall risk assessment indicated the resident was frequently incontinent, but some control was present, however, two fall risk assessments indicated the resident was totally incontinent with no control. According to two staff interviewed, the resident was only incontinent at night, and continent during the day, since the time of admission to the home, however the plan of care indicated the resident was totally incontinent from the time of admission. (130)
d) The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of an identified resident so that their assessments were integrated, consistent with and complemented each other. A fall risk assessment indicated the resident was at moderate risk for falls and frequently incontinent, however the previous assessment indicated the resident was high risk for falls and totally incontinent. Another falls assessment indicated the resident was at moderate risk for falls, was totally continent with complete control and had no history of falls, despite a recorded fall. Two fall risk assessments indicated the resident was occasionally incontinent and no history of falls in the past 6 months. Three fall risk assessments indicated the resident was occasionally incontinent. The plan of care and staff interviewed confirmed that when the resident was admitted to the home they were totally incontinent with no control. (130) (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

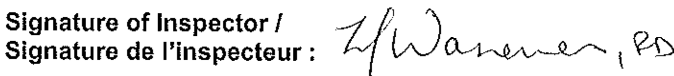
À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 24th day of August, 2012

Signature of Inspector / Signature de l'inspecteur :



Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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