Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'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	2012_066107_0008	Resident Quality Inspection

Licensee/Titulaire de permis

GRACE VILLA LIMITED
284 CENTRAL AVENUE, LONDON, ON, N6B-2C8

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

GRACE VILLA NURSING HOME
45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5

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

MICHELLE WARRENER (107), DEBORA SAVILLE (192), GILLIAN HUNTER (130), TAMMY SZYMANOWSKI (165), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nutrition Manager (NM), Food Service Supervisor (FSS), Programs Manager, Pastoral Care Co-ordinator, Payroll/Scheduling Clerk, Accounting Clerk, Maintenance Manager, Social Worker, Ward Clerk, Assessment and Documentation Manager, front line nursing and dietary staff on all floors, including Personal Support Workers (PSW) and Registered staff, numerous residents and family members

During the course of the inspection, the inspector(s) Observed resident care, meal service, laundry, and housekeeping practices, reviewed clinical health records and relevant policies and procedures related to RQI inspection H-000806-12

Complaint inspections H-002426-11, H-000094-12, H-000165-12, H-000900-12, H-000615-12, H-000860-12 were also inspected during this RQI inspection.
Non-compliance from these complaints was issued as part of this RQI inspection report. The following non-compliance was identified related to the above complaints:
Inspection #2012-149165-0002 and 2012-_066107_009 for inspection H-002426-11 - LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(c); O.Reg. 79/10, s. 50(2)(b)(iv); s. 51(2)(b); s. 8(1)(b).
Inspection #2012_066107_009/H-000094-12 and #2012_105130_0011 for inspection H-000900-12, H-000615-12 - LTCHA, 2007, S.O. 2007, c.8, s. 3(1)11.ii; s. 6(7); O.Reg. 79/10, s. 72(3)(a), s.72(2)(d), s. 71(2)(a),(b); s. 71(4); s. 71 (1)(d),(e).
Inspection #2012_105130_0010 for H-000165-12 - LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1; O.Reg. 79/10, s. 107(3)4

The following Inspection Protocols were used during this inspection:

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Snack Observation

Sufficient Staffing

Trust Accounts

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

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).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(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).

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).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(c)] Previously issued under the Nursing Homes Act, Section 20.10 related to un-met criteria B2.4 and B1.6 January 7, 2010; Previously issued as s. 6(10)(c) on May 24, 2011 as a CO.
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.
2. [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)
3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(2)] Previously issued May 24, 2011 as a VPC.
The licensee did not ensure that the care set out in the plan of care for residents was based on an assessment of the residents and the needs and preferences of the residents.
a) An identified resident stated they preferred to sleep in most days for breakfast, however, their plan of care did not include interventions to accommodate the resident's preference for sleeping in. Staff interview confirmed that the resident routinely slept in over the breakfast meal and food and fluid intake records over one month demonstrated the resident refused the breakfast meal 17/25 days. The resident stated they were not offered a beverage or a later breakfast, which would be their preference, when they slept in. At the observed breakfast meal May 18, 2012 the resident was not offered a beverage or an alternative breakfast meal when they stayed in bed over the breakfast meal. The resident's plan of care did not identify that the resident preferred to sleep in most days over the breakfast meal and stated staff were to encourage the resident to consume specific items at the breakfast meal. The plan of care was not based on the resident's preference of sleeping in and preference for an alternative breakfast upon awakening at a later time. The resident had a weight loss of 6.7% over four months. (107)
b) The plan of care for an identified resident indicated the resident was at high risk for falls and staff were to ensure that their bed was in the lowest position. The resident was observed in bed on May 11, 2012; their bed was not in the lowest position. Staff interviewed stated the resident did not want their bed in the lowest position; the resident confirmed that they preferred their bed not be lowered to the floor. The plan of care was not updated to reflect the resident's preference despite staff knowledge of the resident's choice. (130)
4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)] Previously issued under the Nursing Homes 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.
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)
5. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)] Previously issued under the Nursing Homes Act, section 20.10 January 7, 2010; Previously issued as s. 6(1)(c) on August 17, 2010 as a WN; August 17, 2010 as a WN, September 7, 2010 as a VPC; November 3, 2010 as a VPC; February 1, 2011 as a VPC; September 12, 2011 as a WN.
The licensee did not ensure that there was a written plan of care for each resident that set out clear direction to staff and others who provided direct care to the resident.
a) The plan of care for an identified resident stated the resident was both independent with toileting and also that they required the assistance of one staff member with no clear direction as to when the resident would be independent and when the resident would require assistance. Personal support workers (PSW) staff interviewed confirmed that the plan of care was not clear. (107)
b) The plan of care for an identified resident did not set out clear directions to staff and others who provided direct care. The resident's focus for their personal hygiene plan of care indicated the resident required assistance however, the interventions indicated little or no help was required; set up was required; resident refused assistance with daily care. Staff stated that the resident got scared when care was provided and that the best time to provide care was in the afternoon, however the plan of care did not reflect this.(165)
c) The plan of care for an identified resident and interview of the staff and resident provided conflicting information related to the management of continence. The plan of care indicated that the resident was to be toileted before and after meals, at bedtime and as necessary. Staff interviewed indicated they got the resident up upon request and that a bed pan was used as necessary. Resident interview indicated that the resident remained in bed and their incontinent brief was change by staff. The resident was not observed being toileted. (192)
d) The licensee did not ensure that the plan of care for an identified resident set out clear directions to staff and others who provided direct care. The point click care (PCC) care plan was reviewed by staff and indicated the resident was a high risk for falls related to an extensive history of falls with injury and many risk factors, however, the same care plan indicated the resident was a moderate risk for falls. Staff interviewed confirmed the resident was high risk for falls. (130)
6. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued under the Nursing Homes Act June 8, 2010 under section 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 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.

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)
7. [LTCHA, 2007, S.O. 2007, c.8, s. 6(6)] Previously issued September 12, 2011 as a CO.
The licensee failed to ensure that when a resident was admitted to the long-term care home, within the times provided for in the regulations, that the resident was 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.
An identified resident was admitted to the home, however, a Kardex containing information related to the care required by the resident was not made available to staff until two days later. Staff interviewed confirmed that a copy of the Kardex is used to provide front line staff information found in the plan of care. Interview with registered staff and personal support workers confirmed that no plan of care had been initiated for the resident.
8. [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.
9. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(a)] Previously issued September 7, 2010 as a VPC; May 24, 2011 as a VPC.
The licensee did not ensure that there was a written plan of care for each resident that set out the planned care for the resident.
a) Padded bed rails were noted to be in place for three identified residents, however, the plans of care for these residents did not identify this need.
b) A plan of care that set out the planned care for an identified resident in relation to hygiene and grooming was not in place. The registered practical nurse stated the resident required one person total care and they were very resistive. Staff were able to state specific strategies they used to provide care, however, the registered practical nurse confirmed there was no plan of care developed that included the strategies or plan for the activities of daily living hygiene and grooming. (165)
c) The plan of care for an identified resident did not provide any direction to staff related to their toileting routine, despite confirmation from staff that the resident was dependent on staff for this activity.

Additional Required Actions:

CO # - 901 was served on the licensee. CO # - 001, 002, 003, 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 6(1)(a)and s. 6(1)(c), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following subsections:

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).

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 11(2)] Previously issued September 7, 2010 as a VPC.
The licensee did not ensure that residents were provided with foods that were safe, adequate in quantity, nutritious and varied.
a) Not all foods were prepared in a manner that prevented cross contamination and was safe for residents requiring a specific allergen free menu. Staff preparing the dinner meal May 22, 2012 used the same knife and lifter for cutting and portioning foods that contained the allergen and those that did not. The same margarine container was used with utensils that contacted foods containing the allergen and those that were allergen free. Staff confirmed the same utensils were used for allergen containing and allergen free menu items, creating cross contamination and a risk for negative outcomes for residents requiring the specialized menu.
b) Not all planned menu items were adequate in quantity. The lunch meal May 17, 2012 provided a planned portion of 3 perogies, 1 slice of bacon was planned in the recipe for the bacon tomato sandwich, the portion size of diced tomatoes served with a hot dog was 60ml and was insufficient as a serving of vegetables, 1 cabbage roll was planned as an entree (7.8grams protein).
c) The food served to residents on the planned menu was not consistently varied and nutritious.
i) The same items were repeated throughout the 3 week menu cycle and similar items were served on consecutive days. Resident interviews identified concerns with variety on the menus. Some examples: Week 1 Friday and Week 2 Wednesday both lunch menu choices are beef products and beef was served again for the supper meals on both days; ground beef was served Week 2 Wednesday dinner, Thursday lunch and dinner and Week 3 Thursday lunch and dinner and Friday lunch and Saturday dinner; mayo type sandwiches were served Week 1 Monday and Tuesday lunch; breakfast type items were served for the lunch meal at least once per week; sausages, hot dogs, breaded meats, and other items were served multiple times in the three week menu cycle without documentation to support the repetition was requested by the residents of the home.
ii) Many of the entrees for lunch and dinner were highly processed foods that were not nutrient dense and nutritious (57% of entrees each week were processed food items, or breaded/cured meats containing minimally dense protein).
d) The Food Service Manager and Registered Dietitian confirmed there were concerns with the current menu.
2. [LTCHA, 2007, S.O. 2007, c.8, s. 11(1)(b)]
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 1000 ml/day.

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

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.
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)
2. [O.Reg. 79/10, s.50(2)(c)] Previously issued May 24, 2011 as a VPC.
The licensee did not ensure that equipment, supplies, devices and positioning aides referred to in subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.
a) The home did not have Barrier cream available for skin care as part of the skin care program. A PSW approached the inspector to state there wasn't any Barrier cream in the home. They stated they asked the management team to provide some approximately three weeks ago and none had been provided. The ADOC confirmed there wasn't any in the home. (169)
b) An identified resident approached the inspector to voice concerns about a nurse not using barrier cream or peri-wash when providing care to the resident. The resident stated staff were supposed to use the cream and they were upset that the staff did not use it when providing care. (107)

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that equipment, supplies, devices and positioning aides referred to in subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
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.

Findings/Faits saillants :

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 section 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.

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (1) Every licensee of a long-term care home shall ensure that there is an organized food production system in the home. O. Reg. 79/10, s. 72 (1).

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

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).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service;
(b) a cleaning schedule for all the equipment; and
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :