Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 27, 2017	2017_486653_0021	025109-17	Resident Quality Inspection

Licensee/Titulaire de permis

GROVE PARK HOME FOR SENIOR CITIZENS
234 COOK STREET BARRIE ON L4M 4H5

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

GROVE PARK HOME FOR SENIOR CITIZENS
234 COOK STREET BARRIE ON L4M 4H5

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

ROMELA VILLASPIR (653), DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 7, 9, 10, 14, 15, 16, 17, 20, 21, 22, 23, and 24, 2017.

The following were inspected concurrently during this inspection: Log #011594-17, related to falls prevention.

During the course of the inspection, the inspector (s) conducted a tour of the home, observed medication administration, observed staff to resident interactions, reviewed staff schedule, clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Dietary Aides (DAs), Life Enrichment Aide (LEA), Restorative Care Aide (RCA), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Registered Dietitian (RD), Manager of Food and Nutrition, Director of Care (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was offered a minimum of three meals daily.

During stage one of the Resident Quality Inspection (RQI), resident #002 was triggered related to no plan – low Body Mass Index (BMI).

Review of the home's posted therapeutic menu revealed the following food items to be offered during the breakfast meal service on an identified date: Hot oatmeal, scrambled eggs, toast, blueberry muffins, assorted juice and assorted cold cereal.

During an observation of the resident on an identified date and time period, the following were noted:
-Resident #002 remained in bed and no staff member was observed to enter the resident's room to offer breakfast meal.
-Two staff members entered the room and provided morning care. Afterwards, the resident was brought into the activity room and provided with food items and fluids from the tea cart.

Interviews with Personal Support Worker (PSW) #111 and Registered Practical Nurse (RPN) #112 confirmed the above mentioned information and further indicated that this was the normal occurrence when resident #002 was too sleepy to have breakfast in the dining room. Both staff confirmed that resident #002 had not been offered a minimum of three meals daily.

Interview with the Registered Dietitian (RD) acknowledged the above mentioned information and confirmed that resident #002 had not been offered a minimum of three meals daily. [s. 71. (3) (a)]

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

During stage one of the RQI, residents #002 and #004 were triggered related to no plan - low BMI.

Review of the home's posted therapeutic menu identified 250 mLs of milk were to be offered at every meal.

During an observation of the resident on an identified date and time period, the following

were noted:
-Resident #002 remained in bed and no staff member was observed to enter the resident's room to offer breakfast meal.
-Two staff members entered the room and provided morning care. Afterwards, the resident was brought into the activity room and provided with food items and fluids from the tea cart. Milk was not offered to resident #002, which was confirmed by PSW #111.

During an observation of resident #004 on an identified date, during the lunch meal service, PSW #111 was observed offering resident #004 a 250 mL glass of juice and not milk. The resident was also observed during the breakfast meal service on an identified date, wherein 250 mLs of milk were also not offered.

Resident #004's plan of care and dietary kardex did not identify milk as a dislike. The inspector attempted to interview resident #004, however, the resident was not interviewable.

Interview with PSW #120 identified that he/ she thought the fluid standard at meals were two beverages, a juice and coffee/ tea. He/ she further indicated that milk was served if the resident requested it or if it was care planned to be offered.

Interview with RPN #112 who supervised the dining room, acknowledged that he/ she was unaware of the standard for what type of fluid and what amount should be offered and served during meals, and that he/ she thought it was milk and water.

Interview with the RD and the Manager of Food and Nutrition (MFN) confirmed that 250 mLs of milk were to be offered at each meal as part of the planned menu. Both the RD and the MFN further indicated that milk was required to be offered as part of the nutritional requirements of the planned menu. [s. 71. (4)]

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was a pattern.

A review of the home's compliance history within the last three years revealed a Written Notification (W) had been previously issued for an area of non-compliance related to the Long-Term Care Homes Act, 2007, Ontario Regulation 79/10, s. 71. within the following inspection report:
-#2016_273638_0010 dated July 29, 2016.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of three meals daily, and that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with, and complemented each other.

During stage one of the RQI, resident #001 was triggered related to potential side rail restraint.

Observations conducted on two identified dates and times, revealed resident #001's two quarter side rails were noted to be up without the resident in bed.

Review of resident #001's bed rail assessment on an identified date, completed by the Restorative Care Aide (RCA), revealed the resident required bed rails for rolling side to side during care and that the bed rails promoted his/ her participation in Activities of the Daily Living (ADLs).

Review of resident #001's written plan of care on an identified date, indicated he/ she required the use of two quarter bed rails for repositioning and bed mobility.

The inspector attempted to interview resident #001, however, the resident was not interviewable.

Interviews with PSW #105 and RPN #106 confirmed that resident #001 was totally dependent on staff for all ADLs including repositioning and bed mobility. They further indicated that the resident had not been able to use the bed rails for repositioning and bed mobility due to limitations on his/ her upper and lower extremities.

Interview with the RCA confirmed he/ she did not communicate with the PSW and the registered staff when he/ she completed resident #001's most recent bed rail assessment. The RCA further acknowledged that in this case, the staff did not collaborate in the assessment of the resident for bed rail use.

Interview with the Director of Care (DOC) acknowledged the above mentioned information, and further indicated that the home's expectation was for the interdisciplinary staff to collaborate with each other in the assessment of the resident. [s. 6. (4) (a)]

2. During stage one of the RQI, resident #002 was triggered related to no plan – low BMI.

Review of the RD's progress note on an identified date, revealed that the resident had a BMI at the low end of acceptable range. Review of the resident's written plan of care identified him/ her being at high nutritional risk.

During an observation of the resident on an identified date and time period, the following were noted:
-Resident #002 remained in bed and no staff member was observed to enter the resident's room to offer breakfast meal.
-Two staff members entered the room and provided morning care. Afterwards, the resident was brought into the activity room and provided with food items and fluids from

the tea cart.

Interview with DA #113 when asked if all residents received breakfast, he/ she stated all residents did, except for resident #002, as he/ she was usually sleepy in the morning, and gets something from the tea cart instead. The DA further indicated he/ she prepared a sandwich for the resident to eat from the tea cart.

Review of the Point of Care (POC) look back report from an identified time period, under the "eating" task, revealed PSW documentation of resident refusing breakfast on 14 occasions.

Interviews with PSW #111 and RPN #112 confirmed the above mentioned information and further indicated that this was the normal occurrence when resident #002 was too sleepy to have breakfast in the dining room. Both staff further indicated that the resident would normally get a sandwich from the tea cart when he/ she missed the breakfast meal. The PSW further acknowledged that the multiple documentations on POC of resident #002 refusing meal were prompted from him/ her being too sleepy in the morning and not receiving the full breakfast meal. RPN #112 further confirmed that he/ she had been aware that the resident would sleep in the morning, and staff would not save and offer the full breakfast meal as per the therapeutic menu. Instead, the staff would usually provide a sandwich from the tea cart.

Interview with the RD confirmed he/ she had not been aware that resident #002 had been missing meals. He/ she further indicated that the nursing staff did not inform him/ her that resident #002 had been sleeping in the morning and that the staff had been providing a sandwich from the tea cart as an alternative for the full breakfast meal. The RD stated his/ her expectation was for the staff to communicate this information to him/ her and put in a referral for the resident so he/ she can assess accordingly and plan a good appropriate breakfast for the resident if he/ she was not waking up during the breakfast meal service. The RD confirmed the lack of collaboration in the assessment of resident #002. [s. 6. (4) (a)]

3. During stage one of the RQI, resident #003 was triggered related to no plan – low BMI.

Record review of the Resident Assessment Instrument-Multiple Data Set (RAI-MDS) quarterly assessment by the RD identified that resident #003 had a desirable weight gain over the past year but his/ her BMI remains below his/ her average body weight range. The assessment identified the resident was at high nutritional risk.

Record review of resident's written plan of care revealed resident #003 usually goes to the dining room, but on most days will come and go throughout the meal. The written plan of care identified nutrition interventions to promote the resident's food intake.

During an observation on an identified date and time, the resident was noted to be early in the dining room and served cereal, eating independently, and then remained in the dining room for a full breakfast meal. Resident's intake was 75-100 per cent.

Interview with PSW #121 identified that resident is up a lot at an identified time. The PSW revealed the resident's intake at an identified meal service was usually 25 per cent, but at an identified time, was the resident's highest peak when he/ she is awake and staff give him/ her food. PSW identified that in the past there were snack bins with different options now it is the same sandwiches, cookies, pudding and cheese. PSW continued to state that resident #003 is active at an identified time, easy to enhance his/ her intake as he/ she is willing to eat, but the same sandwich is made all the time.

Interview with PSW #122 revealed that resident #003 is often up at an identified time and that staff will offer him/ her food. Interview with RPN #123 revealed that resident #003's intake is a hit and miss and that resident wants to eat at an identified time. The RPN revealed that she makes platters of peanut butter sandwiches and bananas at an identified time, and that there are limited food choices for staff to prepare items of interest for residents, like resident #003.

Interview with the MFN revealed that nursing staff communicate with dietary by way of an e-mail or referral. The MFN revealed he/ she was unaware that resident #003 was being offered foods during the identified time, and that limited options were available to staff and the resident. The MFN stated that there was a lack of collaboration as dietary could customize a menu for resident #003 to meet his/ her needs and desire to eat at the identified time.

Interview with the RD revealed that he/ she was unaware of the resident's hunger and intake as mentioned above, as there had been no documentation in the resident's health record other than staff offering cereal on one occasion. The RD confirmed resident #004 was at high nutritional risk, and had variable intake. He/ she further indicated that there was a lack of collaboration between dietary and nursing in the assessment of resident #003. [s. 6. (4) (a)]

4. During stage one of the RQI, resident #004 was triggered related to no plan – low BMI.

Record review of the resident's written plan of care identified resident #004 at high nutritional risk related to behaviours at meals, being easily distracted and having a reduced intake. The written plan of care indicated nutrition interventions with two identified nutritional supplement drinks to be given to the resident, and staff to continue to monitor fluid intake/ output daily and offer additional fluids above the resident's meal times.

During an observation on an identified date, during the lunch meal service, it was observed that the resident was offered an identified diet drink and sugar substitute sweetener for his/ her coffee.

Interviews with PSWs #111 and #120 revealed that resident #004 likes to open the packages of sugar and further indicated that the resident was unaware that it was a low calorie sugar substitute, and that packages of regular sugar were not available. Staff confirmed this practice had been in place for a year or more. PSW #111 identified that the identified drink was a preferred flavour of the resident and a diet drink was only available in this flavour. The PSW revealed that the resident takes the identified diet drink regularly and identified that both options were not in keeping with the resident's special diet.

Interview with RPN #112 confirmed that staff offering diet drinks and a low calorie sugar substitute were not consistent with the resident's special diet, and further indicated that there was a lack of collaboration with the dietary department.

Interview with the MFN revealed that nursing staff communicate with dietary by way of an e-mail or referral. The MFN further indicated that he/ she had not been made aware of resident #004's preferences. The MFN identified there was a lack of collaboration between departments in the assessment of resident #004. [s. 6. (4) (a)]

5. The licensee has failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

During stage one of the RQI, resident #002 was triggered related to no plan – low BMI.

Review of resident #002's written plan of care indicated that if he/ she is too sleepy to eat meal at meal times, save and provide later when alert, and ensure intake is recorded in

POC.

Review of the home's posted therapeutic menu revealed the following food items to be offered during the breakfast meal service on an identified date: Hot oatmeal, scrambled eggs, toast, blueberry muffins, assorted juice and assorted cold cereal.

During an observation of the resident on an identified date and time period, the following were noted:
-Resident #002 remained in bed and no staff member was observed to enter the resident's room to offer breakfast meal.
-Two staff members entered the room and provided morning care. Afterwards, the resident was brought into the activity room and provided with food items and fluids from the tea cart.

Interview with DA #113 when asked if all residents received breakfast, he/ she stated all residents did, except for resident #002, as he/ she was usually sleepy in the morning, and gets something from the tea cart instead. The DA further indicated he/ she prepared a sandwich for the resident to eat from the tea cart.

Interviews with PSW #111 and RPN #112 confirmed the above mentioned information and further indicated that this was the normal occurrence when resident #002 was too sleepy to have breakfast in the dining room. Both staff further indicated that the resident would normally get a sandwich from the tea cart when he/ she missed the breakfast meal. PSW #111 and RPN #112 both acknowledged that care had not been provided as specified in the resident's plan of care, as the entire breakfast meal was not saved and provided to the resident.

Interview with the RD acknowledged the above mentioned information and confirmed that care had not been provided to the resident as specified in his/ her plan of care, as the staff did not save and provide the breakfast meal as per the home's planned menu. [s. 6. (7)]

6. On an identified date and time, the home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS indicated that on an identified date and time, resident #006 had a witnessed fall resulting in hospitalization.

Review of resident #006's Fall Risk Quarterly Assessment and written plan of care on an identified date, revealed he/ she was at high risk for falls. The written plan of care indicated numerous falls prevention interventions.

Review of progress note on an identified date, revealed resident #006 had a witnessed fall at an identified time. Life Enrichment Aide (LEA) #115 had gone into the resident's room to see if he/ she wanted to come to an activity, shortly before the fall had occurred. Resident #006 was witnessed to have fallen sustaining injury. The resident was transferred to the hospital post fall.

Interview with LEA #115 revealed during that morning, he/ she went to resident #006's room to see if he/ she wanted to come to an activity. When the LEA entered the room, he/ she found resident #006 in his/ her bathroom standing by the sink, and the resident's wheelchair was facing the toilet. LEA #115 stated it appeared as if the resident had just gone to the toilet and forgot to sit back on his/ her wheelchair. He/ she was aware that the resident was at risk for falls and should not be standing up by himself/ herself so the LEA encouraged the resident to sit back on his/ her wheelchair. The LEA then observed the resident falling over the armoire in the room hitting his/ her identified body part on his/ her way down to the floor. LEA #115 called for assistance and the nurses arrived immediately.

Interview with PSW #114 confirmed he/ she was with resident #006 the morning of the incident. After providing the resident's morning care, he/ she left resident #006 sitting in his/ her wheelchair by the window before leaving him/ her in the room. PSW #114 confirmed he/ she forgot to apply resident #006's identified falls prevention intervention when he/ she left the resident in the wheelchair in his/ her room. The PSW confirmed he/ she did not follow resident #006's written plan of care in regards to application the identified falls prevention intervention.

Interview with Registered Nurse (RN) #108 stated that during the morning of the incident, he/ she was called by staff members to resident #006's room. The RN attended to the resident and found him/ her lying on the floor in his/ her bedroom with an injury on his/ her identified body part. He/ she further indicated that the paramedics had been called and the resident was transferred to the hospital.

Review of progress note from an identified date and time, indicated the hospital physician phoned the nurse and stated that the resident's diagnostic test showed a significant

diagnosis. On the same day, it was documented that resident #006 returned to the home from the hospital with palliative orders. Four days later, progress notes revealed resident #006 had passed away in the home.

Interview with the DOC acknowledged the above mentioned incident and further confirmed that PSW #114 had not provided care to the resident as specified in the plan of care, which resulted in actual harm that negatively affected resident #006.

The severity of the non-compliance was actual harm.

The scope of the non-compliance was isolated to resident #006.

A review of the home's compliance history within the last three years revealed Voluntary Plan of Corrections (VPCs) were previously issued for non-compliances related to the Long-Term Care Homes Act, 2007, s. 6. (7) within the following inspection reports:
-#2016_273638_0010 dated July 29, 2016,
-#2016_168202_0002 dated January 22, 2016,
-#2015_299559_0009 dated May 8, 2015. [s. 6. (7)]

7. During stage one of the RQI, resident #004 was triggered related to no plan - low BMI.

Record review of the resident's written plan of care identified resident #004 at high nutritional risk related to behaviours at meals, being easily distracted and having a reduced intake. It also indicated that the resident's goal was to prevent significant weight loss, and achieve and maintain weight within an identified range. The written plan of care indicated nutrition interventions with two identified nutritional supplement drinks to be given to the resident, and staff to continue to monitor fluid intake/ output daily and offer additional fluids above the resident's meal times.

Record review of the resident's Weight Summary Report revealed that on an identified date, he/ she weighed below the identified weight range.

Record review identified a nutritional supplement to be given three times daily, was ordered on an identified date. Review of the electronic Medication Administration Records (eMARs) for a period of six months, revealed that the supplement had not been administered to the resident. Interview with RPN #112, confirmed that the nutritional supplement had not been transcribed correctly and not entered into the eMARS to be

administered.

During an observation on an identified date and meal service, it was noted that resident #004 was not served the identified nutritional supplement drink, which was confirmed by PSW #111 and DA #124.

Interview with PSW #120 identified that resident #004 had not been receiving the identified nutritional supplement drink at the identified meal service all the time and that he/ she was aware of the residents who did, and that resident #004 was not one of them.

Interview with the RD and MFN confirmed that resident #004's written plan of care had not be followed. [s. 6. (7)]

8. During stage one of the RQI, resident #002 was triggered related to no plan – low BMI.

Review of resident #002's written plan of care directed the staff to provide an identified diet texture and to provide a variety of identified nutritional food items. The written plan of care also directed staff to provide an identified assistive drinking device so the resident can drink independently. Review of the dietary kardex in the dining room indicated that resident #002 was supposed to receive two identified nutritional food items in his/ her cereals at breakfast, and is supposed to be provided an assistive drinking device.

Review of the home's posted therapeutic menu revealed the following food items to be offered during the breakfast meal service on an identified date: Hot oatmeal, scrambled eggs, toast, blueberry muffins, assorted juice and assorted cold cereal.

During an observation of the resident on an identified date and time period, the following were noted:
-Resident #002 remained in bed and no staff member was observed to enter the resident's room to offer breakfast meal.
-Two staff members entered the room and provided morning care. Afterwards, the resident was brought into the activity room and provided with food items and fluids from the tea cart, which were inconsistent with the resident's diet texture. Resident #002 was also not provided with the identified assistive drinking device when given the fluids.

Interviews with PSW #111 and RPN #112 confirmed that above mentioned observations, and further acknowledged that resident #002 was supposed to have an assistive drinking

device because he/ she has a hard time drinking directly from the glass and may spill his/ her drinks on his/ her clothes. The PSW and the RPN also confirmed that as a result of the resident not being offered the full breakfast meal including the cereals, he/ she did not receive the two identified nutritional food items in his/ her cereals at breakfast as indicated in his/ her written plan of care. Both staff confirmed that the care set out in resident #002's written plan of care had not been provided to the resident.

Interview with the RD acknowledged the above mentioned information and confirmed that care had not been provided to the resident as specified in his/ her plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
-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,
-that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 114 (2), The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Record review of MediSystem Pharmacy's policy titled "Narcotic and Controlled Substances Administration Record" last reviewed January 17, 2017, indicated under procedure that all entries must be made at the time the drug is removed from the container.

On November 17, 2017, at 1045 hrs on an identified unit, inspector #653 and RPN #104 reviewed the narcotic count documentation in conjunction with the current narcotic supply of medication. Inspector #653 and RPN #104 observed the following discrepancies:

-Resident #011's narcotic blister pack consisted of 8.5 tablets, whereas the the Narcotic and Controlled Drug Administration Record (NCDAR) sheet indicated he/ she had 9 tablets remaining.
-Resident #012's narcotic blister pack consisted of 5 capsules, whereas the NCDAR sheet indicated he/ she had 6 capsules remaining.
-Resident #013's narcotic blister pack consisted of 11 capsules, whereas the NCDAR sheet indicated he/ she had 12 capsules remaining.
-Resident #014's narcotic blister pack consisted of 5.5 tablets, whereas the NCDAR

sheet indicated he/ she had 6 tablets remaining.
-Resident #015's narcotic blister pack consisted of 11 capsules, whereas the NCDAR sheet indicated he/ she had 12 capsules remaining.
-Resident #016's narcotic blister pack consisted of 11 tablets, whereas the NCDAR sheet indicated he/ she had 12 tablets remaining.
-Resident #017's narcotic blister pack consisted of 5 tablets, whereas the NCDAR sheet indicated he/ she had 6 tablets remaining.
-Resident #017's narcotic blister pack consisted of 5 tablets, whereas the NCDAR sheet indicated he/ she had 6 tablets remaining.
-Resident #017's narcotic blister pack consisted of 5 capsules, whereas the NCDAR sheet indicated he/ she had 6 capsules remaining.
-Resident #018's narcotic blister pack consisted of 8.5 tablets, whereas the NCDAR sheet indicated he/ she had 9 tablets remaining.

Interview with RPN #104 confirmed he/ she did not sign the above mentioned NCDAR sheets following the narcotic drug administration, as he/ she did not have time. The RPN further acknowledged that he/ she did not follow the home's policy, as he/ she was required to sign the NCDAR sheet right after each narcotic drug administration.

Interview with the DOC confirmed the above mentioned information and further indicated that the home's expectation was for the registered staff to sign the NCDAR sheets right after they had administered the narcotic drug as required by the policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy on Narcotic and Controlled Substances Administration Record is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who is a member of the staff of the home, assessed the resident's nutritional status, including height, weight and any risks related to nutrition care, and assess hydration status, and any risks related to hydration.

During stage one of the RQI, resident #004 was triggered related to no plan - low BMI.

Review of the RAI-MDS annual assessment identified a nutritional problem related to resident #004 leaving 25 per cent or more of food uneaten at most meals, and being at risk for dehydration related to the use of an identified medication.

Record review of the resident's written plan of care identified resident #004 at high nutritional risk related to behaviours at meals, being easily distracted and having a reduced intake. It also indicated that the resident's goal was to prevent significant weight loss, and achieve and maintain weight within an identified range. The written plan of care indicated nutrition interventions with two identified nutritional supplement drinks to be given to the resident, and staff to continue to monitor fluid intake/ output daily and offer additional fluids above the resident's meal times.

Record review of the resident's Weight Summary Report revealed that on an identified date, he/ she weighed below the identified weight range.

Record review identified a nutritional supplement to be given three times daily, was ordered on an identified date. Review of the eMARs for a period of six months, revealed that the supplement had not been administered to the resident. Interview with RPN #112, confirmed that the nutritional supplement had not been transcribed correctly and not

entered into the eMARS to be administered.

During an observation on an identified date during the lunch meal service, it was noted that resident #004 was not served the identified nutritional supplement, which was confirmed by PSW #111 and DA #124. It was also observed that the resident was offered an identified diet drink and sugar substitute sweetener for his/ her coffee. PSW #111 revealed that the resident takes the identified diet drink regularly and identified that both options were not in keeping with the resident's special diet. Interview with RPN #112 confirmed that staff offering diet drinks and a low calorie sugar substitute were not consistent with the special diet.

Interview with PSW #120 identified that resident #004 had not been receiving the identified nutritional supplement at lunch all the time and that he/ she was aware of the residents who did, and that resident #004 was not one of them.

Resident #004 was also observed during two different meal services on two identified dates. On both occasions, he/ she was not offered 250 mLs of milk as required by the planned menu and confirmed by the MFN.

Interview with the RD revealed he/ she was unaware that resident #004 was not served milk, in accordance to the planned menu, that diet drinks and sugar substitutes were offered and consumed by the resident, that the two identified nutritional supplements were not provided as ordered. The RD identified that these components of resident #004’s intake were not assessed and could place the resident at nutrition/ hydration risk. [s. 26. (4) (a),s. 26. (4) (b)]

2. During stage one of the RQI, resident #003 was triggered related to no plan – low BMI.

Record review of the RAI-MDS quarterly assessment by the RD identified that resident #003 had a desirable weight gain over the past year but his/ her BMI remains below his/ her average body weight range. The assessment identified the resident was at high nutritional risk.

Record review of resident’s written plan of care revealed resident #003 usually goes to the dining room, but on most days will come and go throughout the meal. The written plan of care identified nutrition interventions to promote the resident's food intake.

During an observation on an identified date and time, the resident was noted to be early in the dining room and served cereal, eating independently, and then remained in the dining room for a full breakfast meal. Resident's intake was 75-100 per cent.

Interview with PSW #121 identified that resident is up a lot at an identified time. The PSW revealed the resident's intake at an identified meal service was usually 25 per cent, but at an identified time, was the resident's highest peak when he/ she is awake and staff give him/ her food. PSW identified that in the past there were snack bins with different options now it is the same sandwiches, cookies, pudding and cheese. PSW continued to state that resident #003 is active at an identified time, easy to enhance his/ her intake as he/ she is willing to eat, but the same sandwich is made all the time.

Interview with PSW #122 revealed that resident #003 is often up at an identified time and that staff will offer him/ her food. Interview with RPN #123 revealed that resident #003's intake is a hit and miss and that resident wants to eat at an identified time. The RPN revealed that she makes platters of peanut butter sandwiches and bananas at an identified time, and that there are limited food choices for staff to prepare items of interest for residents, like resident #003.

Interview with the MFN revealed that nursing staff collaborate with dietary by way of an e-mail or referral. The MFN revealed he/ she was unaware that resident #003 was being offered foods throughout the night and limited options were available to staff and the resident.

Interview with the RD revealed that a BMI of 22 was his/ her guideline to identify residents who are at nutritional risk, and that resident #003's BMI was below 22. Interview with the RD revealed that he/ she was unaware of the resident's hunger and intake and the staff were making peanut butter sandwiches with not enough options available as mentioned above. The RD revealed that nursing staff have not documented they were preparing and serving sandwiches to resident #003. The RD identified that resident #003's hunger and preference for eating during an identified time, had not been assessed. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that a registered dietitian who is a member of the staff of the home, (a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration programs included the identification of any risks related to nutrition care and dietary services and hydration.

Mealtime observations and staff interviews identified that two different nutritional supplements were not provided to resident #004 as ordered, and that milk, as part of the menu, was not being offered to all residents at each meal.

An interview with the MFN identified that staff not offering milk according to the planned menu could impact residents by way of not having access to all fluid at meals and to the nutritional requirements of the menu. The MFN acknowledged that not providing nutrition interventions as ordered and milk as planned were risks to receiving adequate nutrition.

The MFN confirmed that the nutrition care and hydration program failed to identify these risks, by way of auditing adherence to the menu and the provision of care plan interventions. [s. 68. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition and hydration program include the identification of any risks related to nutrition care and dietary services and hydration, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction had been reported to the resident, the resident's SDM, if any, and the resident's attending physician.

As part of the RQI, all medication incidents and adverse drug reactions from the past quarter that had been analyzed and evaluated in the home's most recent Joint Health Advisory Committee Meeting, had been reviewed.

Interview with RPN #104 stated that when a medication incident occurred, the registered staff who discovered the error would assess and monitor the resident, notify the charge nurse, physician, and/ or Nurse Practitioner (NP), the DOC, resident and/ or the Substitute Decision-Maker (SDM). The registered staff would fill out the medication incident report and fax it to pharmacy. He/ she further indicated that all of the details surrounding the medication incident would also be documented in the progress notes.

A review of the home's medication incidents from July to September 2017, did not identify any documentation that the physician, resident and/ or SDM had been notified of the medication incidents involving residents #001 and #019.

During an interview, the inspector and the DOC reviewed the above mentioned medication incident reports. The DOC acknowledged the lack of notification to the appropriate individuals following the medication incidents. The DOC further acknowledged that the residents and/ or their SDM, and the attending physician should have been notified of the medication incidents as required. [s. 135. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, and the resident's attending physician, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area that was used exclusively for drugs and drug-related supplies.

During an observation on November 17, 2017, at 1050 hrs, a non-drug related supply was found by RPN #104 and inspector #653 in the narcotic storage bin on an identified unit.

The following non-drug related supply was found:
-small plastic bag with cash and coins.

Interview with the DOC confirmed that the above mentioned non-drug related supply was found with the narcotic drugs in the narcotic storage bin in the Spruce unit. The DOC further indicated that the home's expectation was for drug-related supplies to be the only items stored in the narcotic storage bin. [s. 129. (1) (a)]

Issued on this 29th day of December, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653), DIANE BROWN (110)
Inspection No. / No de l'inspection :	2017_486653_0021
Log No. / No de registre :	025109-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 27, 2017
Licensee / Titulaire de permis :	GROVE PARK HOME FOR SENIOR CITIZENS 234 COOK STREET, BARRIE, ON, L4M-4H5
LTC Home / Foyer de SLD :	GROVE PARK HOME FOR SENIOR CITIZENS 234 COOK STREET, BARRIE, ON, L4M-4H5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Taylor

To GROVE PARK HOME FOR SENIOR CITIZENS, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Order / Ordre :

The Licensee shall do the following:
1. Within seven days of receipt of this order, the Licensee shall ensure that the planned menu items are offered to each resident at each meal and snack, unless otherwise identified in the resident's plan of care.
2. Provide in-service education to all Personal Support Workers (PSWs), registered staff, and dietary staff, on the expectation of offering planned menu items including milk.
3. The in-service education shall identify the rationale of milk being offered, including milk's contribution towards the nutritional requirements of the planned menu and the home's fluid standards.
4. Maintain a record of the in-service education provided, including dates, times, trainers, attendees, and the content.
5. Audit each meal for an entire menu cycle to ensure planned menu items are being offered. The audits shall be available upon the inspector's request.

This order shall be complied no later than March 21, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

During stage one of the Resident Quality Inspection (RQI), residents #002 and #004 were triggered related to no plan - low Body Mass Index (BMI).

Review of the home's posted therapeutic menu identified 250 Millilitres (mLs) of milk were to be offered at every meal.

During an observation of the resident on an identified date and time period, the

following were noted:
-Resident #002 remained in bed and no staff member was observed to enter the resident's room to offer breakfast meal.
-Two staff members entered the room and provided morning care. Afterwards, the resident was brought into the activity room and provided with food items and fluids from the tea cart. Milk was not offered to resident #002, which was confirmed by PSW #111.

During an observation of resident #004 on an identified date, during the lunch meal service, PSW #111 was observed offering resident #004 a 250 mL glass of juice and not milk. The resident was also observed during the breakfast meal service on an identified date, wherein 250 mLs of milk were also not offered.

Resident #004's plan of care and dietary kardex did not identify milk as a dislike. The inspector attempted to interview resident #004, however, the resident was not interviewable.

Interview with PSW #120 identified that he/ she thought the fluid standard at meals were two beverages, a juice and coffee/ tea. He/ she further indicated that milk was served if the resident requested it or if it was care planned to be offered.

Interview with Registered Practical Nurse (RPN) #112 who supervised the dining room, acknowledged that he/ she was unaware of the standard for what type of fluid and what amount should be offered and served during meals, and that he/ she thought it was milk and water.

Interview with the Registered Dietitian (RD) and the Manager of Food and Nutrition (MFN) confirmed that 250 mLs of milk were to be offered at each meal as part of the planned menu. Both the RD and the MFN further indicated that milk was required to be offered as part of the nutritional requirements of the planned menu.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was a pattern.

A review of the home's compliance history within the last three years revealed a Written Notification (W) had been previously issued for an area of non-

compliance related to the Long-Term Care Homes Act, 2007, Ontario Regulation 79/10, s. 71. within the following inspection report:
-#2016_273638_0010 dated July 29, 2016. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 21, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall do the following:
1. Review with all direct care staff the nature of this incident and the importance of following falls prevention interventions as directed by the plan of care.
2. Review the current falls prevention interventions implemented in the home with all direct care staff.
3. Explore case study scenarios focusing on residents who are non-compliant with falls prevention interventions, and present strategies on how staff should manage in these cases.
4. Maintain a record of the education provided, including dates, times, trainers, attendees, and material taught.

The above mentioned documentation shall be available to the inspector upon request. This order shall be complied no later than March 21, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

On an identified date and time, the home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS indicated that on an identified date and time, resident #006 had a witnessed fall resulting in hospitalization.

Review of resident #006's Fall Risk Quarterly Assessment and written plan of care on an identified date, revealed he/ she was at high risk for falls. The written

plan of care indicated numerous falls prevention interventions.

Review of progress note on an identified date, revealed resident #006 had a witnessed fall at an identified time. Life Enrichment Aide (LEA) #115 had gone into the resident's room to see if he/ she wanted to come to an activity, shortly before the fall had occurred. Resident #006 was witnessed to have fallen sustaining injury. The resident was transferred to the hospital post fall.

Interview with LEA #115 revealed during that morning, he/ she went to resident #006's room to see if he/ she wanted to come to an activity. When the LEA entered the room, he/ she found resident #006 in his/ her bathroom standing by the sink, and the resident's wheelchair was facing the toilet. LEA #115 stated it appeared as if the resident had just gone to the toilet and forgot to sit back on his/ her wheelchair. He/ she was aware that the resident was at risk for falls and should not be standing up by himself/ herself so the LEA encouraged the resident to sit back on his/ her wheelchair. The LEA then observed the resident falling over the armoire in the room hitting his/ her identified body part on his/ her way down to the floor. LEA #115 called for assistance and the nurses arrived immediately.

Interview with PSW #114 confirmed he/ she was with resident #006 the morning of the incident. After providing the resident's morning care, he/ she left resident #006 sitting in his/ her wheelchair by the window before leaving him/ her in the room. PSW #114 confirmed he/ she forgot to apply resident #006's identified falls prevention intervention when he/ she left the resident in the wheelchair in his/ her room. The PSW confirmed he/ she did not follow resident #006's written plan of care in regards to application the identified falls prevention intervention.

Interview with Registered Nurse (RN) #108 stated that during the morning of the incident, he/ she was called by staff members to resident #006's room. The RN attended to the resident and found him/ her lying on the floor in his/ her bedroom with an injury on his/ her identified body part. He/ she further indicated that the paramedics had been called and the resident was transferred to the hospital.

Review of progress note from an identified date and time, indicated the hospital physician phoned the nurse and stated that the resident's diagnostic test showed a significant diagnosis. On the same day, it was documented that resident #006 returned to the home from the hospital with palliative orders. Four days later, progress notes revealed resident #006 had passed away in the

home.

Interview with the Director of Care (DOC) acknowledged the above mentioned incident and further confirmed that PSW #114 had not provided care to the resident as specified in the plan of care, which resulted in actual harm that negatively affected resident #006.

The severity of the non-compliance was actual harm.

The scope of the non-compliance was isolated to resident #006.

A review of the home's compliance history within the last three years revealed Voluntary Plan of Corrections (VPCs) were previously issued for non-compliances related to the Long-Term Care Homes Act, 2007, s. 6. (7) within the following inspection reports:
-#2016_273638_0010 dated July 29, 2016,
-#2016_168202_0002 dated January 22, 2016,
-#2015_299559_0009 dated May 8, 2015. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 21, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 shall do the following:
1. Upon receipt of this order, a meeting shall be held between nursing and dietary departments to collaborate on the assessments of residents #002, #003, and #004, to ensure that their assessments are integrated, consistent with, and complement each other.
2. Within 30 days of this order, the Licensee shall develop a policy and procedure to direct staff and others involved in the nutritional aspects of resident care, on how to collaborate in the assessment of residents who are at nutrition and hydration risk.
3. The policy shall include a list of resident risk factors, such as resident complaints of hunger, consistently missing a meal etc., to direct nursing staff on when to communicate issues to dietary.
4. The policy and procedure shall be implemented no later than March 21, 2018.
5. An interdisciplinary review of all residents at high nutritional risk shall be completed to ensure that the assessments by staff involved in the different aspects of care, are integrated, consistent with, and complement each other.
6. A list of all residents at high nutritional risk that had been reviewed by the interdisciplinary team shall be available upon the inspector's request.
7. The home shall develop a system to audit ongoing staff collaboration as it relates to residents' nutrition and hydration care. The audit shall be available upon the inspector's request.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with, and complemented each other.

During stage one of the RQI, resident #004 was triggered related to no plan – low BMI.

Record review of the resident's written plan of care identified resident #004 at high nutritional risk related to behaviours at meals, being easily distracted and having a reduced intake. The written plan of care indicated nutrition interventions with two identified nutritional supplement drinks to be given to the resident, and staff to continue to monitor fluid intake/ output daily and offer additional fluids above the resident's meal times.

During an observation on an identified date, during the lunch meal service, it was observed that the resident was offered an identified diet drink and sugar substitute sweetener for his/ her coffee.

Interviews with PSWs #111 and #120 revealed that resident #004 likes to open the packages of sugar and further indicated that the resident was unaware that it was a low calorie sugar substitute, and that packages of regular sugar were not available. Staff confirmed this practice had been in place for a year or more. PSW #111 identified that the identified drink was a preferred flavour of the resident and a diet drink was only available in this flavour. The PSW revealed that the resident takes the identified diet drink regularly and identified that both options were not in keeping with the resident's special diet.

Interview with RPN #112 confirmed that staff offering diet drinks and a low calorie sugar substitute were not consistent with the resident's special diet, and further indicated that there was a lack of collaboration with the dietary department.

Interview with the MFN revealed that nursing staff communicate with dietary by way of an e-mail or referral. The MFN further indicated that he/ she had not been made aware of resident #004's preferences. The MFN identified there was a lack of collaboration between departments in the assessment of resident #004.

(653)

2. During stage one of the RQI, resident #003 was triggered related to no plan – low BMI.

Record review of the Resident Assessment Instrument-Multiple Data Set (RAI-MDS) quarterly assessment by the RD identified that resident #003 had a desirable weight gain over the past year but his/ her BMI remains below his/ her average body weight range. The assessment identified the resident was at high nutritional risk.

Record review of resident's written plan of care revealed resident #003 usually goes to the dining room, but on most days will come and go throughout the meal. The written plan of care identified nutrition interventions to promote the resident's food intake.

During an observation on an identified date and time, the resident was noted to be early in the dining room and served cereal, eating independently, and then remained in the dining room for a full breakfast meal. Resident's intake was 75-100 per cent.

Interview with PSW #121 identified that resident is up a lot at an identified time. The PSW revealed the resident's intake at an identified meal service was usually 25 per cent, but at an identified time, was the resident's highest peak when he/ she is awake and staff give him/ her food. PSW identified that in the past there were snack bins with different options now it is the same sandwiches, cookies, pudding and cheese. PSW continued to state that resident #003 is active at an identified time, easy to enhance his/ her intake as he/ she is willing to eat, but the same sandwich is made all the time.

Interview with PSW #122 revealed that resident #003 is often up at an identified time and that staff will offer him/ her food. Interview with RPN #123 revealed that resident #003's intake is a hit and miss and that resident wants to eat at an identified time. The RPN revealed that she makes platters of peanut butter sandwiches and bananas at an identified time, and that there are limited food choices for staff to prepare items of interest for residents, like resident #003.

Interview with the MFN revealed that nursing staff communicate with dietary by way of an e-mail or referral. The MFN revealed he/ she was unaware that

resident #003 was being offered foods during the identified time, and that limited options were available to staff and the resident. The MFN stated that there was a lack of collaboration as dietary could customize a menu for resident #003 to meet his/ her needs and desire to eat at the identified time.

Interview with the RD revealed that he/ she was unaware of the resident's hunger and intake as mentioned above, as there had been no documentation in the resident's health record other than staff offering cereal on one occasion. The RD confirmed resident #004 was at high nutritional risk, and had variable intake. He/ she further indicated that there was a lack of collaboration between dietary and nursing in the assessment of resident #003.

(653)

3. During stage one of the RQI, resident #002 was triggered related to no plan – low BMI.

Review of the RD's progress note on an identified date, revealed that the resident had a BMI at the low end of acceptable range. Review of the resident's written plan of care identified him/ her being at high nutritional risk.

During an observation of the resident on an identified date and time period, the following were noted:
-Resident #002 remained in bed and no staff member was observed to enter the resident's room to offer breakfast meal.
-Two staff members entered the room and provided morning care. Afterwards, the resident was brought into the activity room and provided with food items and fluids from the tea cart.

Interview with Dietary Aide (DA) #113 when asked if all residents received breakfast, he/ she stated all residents did, except for resident #002, as he/ she was usually sleepy in the morning, and gets something from the tea cart instead. The DA further indicated he/ she prepared a sandwich for the resident to eat from the tea cart.

Review of the Point of Care (POC) look back report from an identified time period, under the "eating" task, revealed PSW documentation of resident refusing breakfast on 14 occasions.

Interviews with PSW #111 and RPN #112 confirmed the above mentioned information and further indicated that this was the normal occurrence when resident #002 was too sleepy to have breakfast in the dining room. Both staff further indicated that the resident would normally get a sandwich from the tea cart when he/ she missed the breakfast meal. The PSW further acknowledged that the multiple documentations on POC of resident #002 refusing meal were prompted from him/ her being too sleepy in the morning and not receiving the full breakfast meal. RPN #112 further confirmed that he/ she had been aware that the resident would sleep in the morning, and staff would not save and offer the full breakfast meal as per the therapeutic menu. Instead, the staff would usually provide a sandwich from the tea cart.

Interview with the RD confirmed he/ she had not been aware that resident #002 had been missing meals. He/ she further indicated that the nursing staff did not inform him/ her that resident #002 had been sleeping in the morning and that the staff had been providing a sandwich from the tea cart as an alternative for the full breakfast meal. The RD stated his/ her expectation was for the staff to communicate this information to him/ her and put in a referral for the resident so he/ she can assess accordingly and plan a good appropriate breakfast for the resident if he/ she was not waking up during the breakfast meal service. The RD confirmed the lack of collaboration in the assessment of resident #002.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was widespread.

A review of the home's compliance history within the last three years revealed VPCs were previously issued for non-compliances related to the Long-Term Care Homes Act, 2007, s. 6. within the following inspection reports:
-#2016_273638_0010 dated July 29, 2016,
-#2016_168202_0002 dated January 22, 2016,
-#2015_299559_0009 dated May 8, 2015. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 21, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

Issued on this 27th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Romela Villaspir

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