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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 03, 2019	2019_556168_0006 (A2)	018917-18, 002010-19	Complaint

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

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

Hardy Terrace
612 Mount Pleasant Road, R.R. #2 BRANTFORD ON N3T 5L5

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

Amended by LISA VINK (168) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

This Inspection Report was amended to correct staff numbers identified in the report.

Issued on this 3 rd day of April, 2019 (A2)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 03, 2019	2019_556168_0006 (A2)	018917-18, 002010-19	Complaint

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

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

Hardy Terrace
612 Mount Pleasant Road, R.R. #2 BRANTFORD ON N3T 5L5

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

Amended by LISA VINK (168) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 7, 8, 11, 12, 13, 15, 18, 19, 20, and 21, 2019.

This Inspection was completed for the following intakes:

Follow-Up Log Number 018917-18, for Compliance Order (CO) #001 from Inspection Report 2018-661683-0008 for O. Reg. 79/10 s 148.

Complaint Log Number 002010-19 from IL-63689-HA related to: responsive behaviours, weight changes, plan of care, protections from certain restraining and resident drug regimes.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Behaviour Supports Ontario (BSO) staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), the registered dietitian (RD), the Food Service Manager (FSM), recreation staff, the Resident Assessment Instrument (RAI) Coordinator, the pharmacist, the physician, residents and family.

During the course of the inspection, the inspector observed the provision of care, reviewed relevant records including but not limited to policies and procedures, clinical health records, training records and program evaluations.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

8 WN(s)
8 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 148. (2)	CO #001	2018_661683_0008	168

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

WN #1: The Licensee has failed to comply with 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 :

(A1)
1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home have, institute or otherwise put in place any

policy, procedure and protocol, that the policy, procedure and protocol was complied with.

A. In accordance with LTCHA, 2007, s. 8, the licensee was required to have an organized program of nursing services in the home to meet the assessed needs of the residents and O. Reg. 79/10, s. 30, required the licensee to ensure that the program of nursing services included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's protocol for an intervention, which was part of the licensee's nursing services program.

On a specified date in February 2019, the DOC identified that the home no longer had a formalized policy or procedure for the intervention; however, had a written protocol or direction, which was previously provided by the Nurse Lead Outreach Team and available to staff.

A review of the information provided direction on the procedure, equipment required, what to document, dosage and troubleshooting. The document was not home specific and did not provide direction regarding where to document in the clinical record the fluid volumes infused.

Interview with the DOC and previously with RN #109, each identified that it was the expectation that the use of the intervention be recorded on the electronic Medication Administration Record (eMAR) and documentation completed each shift in the progress notes for the fluid volume infused.

i. According to the clinical record resident #008 was ordered and received an intervention in February 2019, for a specific period of time, due to a change in status.
The use of the intervention was included in the progress notes; however, it was not identified during a review of the eMAR.
Interview with the DOC following a review of the progress notes, plan of care and eMAR verified that the documentation was not completed as required.

ii. According to the clinical record resident #002 was ordered and received an intervention on three occasions, starting on a specific date in February 2019, due to a change in status.
The use of the intervention was included in the progress notes; however, it was not identified during a review of the eMAR.

Interview with the DOC and RN #109, following a review of the eMAR verified that the documentation was not completed as required.

The protocol was not complied with.

B. In accordance with O Reg 79/10, s. 68, the licensee was required to have a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the licensee's policy and procedure Referral to Dietitian and or Director of Dietary Services, LTC-NAM-E-10.10, effective date January 2015, which identified to "assess all residents for nutritional risk factors and determine if RD referral is necessary in cases such as: unplanned inadequate food intake/appetite experienced for three or more days; food consistently less than 50% consumed at and between meals and poor fluid intake over a 72 hour period and exhibits signs and symptoms of dehydration".

i. According to the plan of care, resident #008 was identified at specific risk, received an intervention and was assessed by the RD for a fluid goal target of a specific number of milliliters (mls) a day.
A review of the Point of Care (POC) records, progress notes and the eMAR identified that since the last assessment by the RD, on a specific date in January 2019, the resident did not consistently achieve their targeted fluid goal.
Fluid intakes were combined as recorded in POC and on the eMAR.
The resident was documented below their targeted fluid intake for periods of 72 hours or greater on three dates in January and February 2019.
A review of the clinical record did not include any referrals for the resident's low fluid intake in January or February 2019.
Interview with the FSM identified that they were unaware of any recent referrals for the resident related to hydration, following a review of the POC records.
A review of the progress notes did not include any assessments of the resident related to signs and symptoms of dehydration for the period of time between the identified dates.
According to the progress notes the resident experienced a change in condition and was assessed on a specific date in February 2019, at which time an intervention was initiated for a period of time, along with additional measures.
Interview with the DOC, following a review of POC records confirmed that according to the policy it was the expectation that a referral was submitted to dietary services.

ii. According to the plan of care, resident #017 was identified at nutritional risk and was assessed by the RD for a fluid goal target of a specific number of mls a day.
A review of the POC records and progress notes identified that since the last assessment by the RD, on a specific date in January 2019, the resident did not consistently achieve their targeted fluid goal.
The resident was documented below their targeted fluid intake for a period of 72 hours on one occasion in February 2019.
A review of the clinical record did not include any referrals for the resident's low fluid intake in February 2019.
Interview with the FSM identified that they were unaware of any recent referrals for the resident related to hydration, following a review of the POC records.
A review of the progress notes did not include any assessments of the resident related to signs and symptoms of dehydration for the period of time identified.
Interview with the DOC, following a review of POC records confirmed that according to the policy it was the expectation that a referral was submitted to dietary services.

iii. According to RN #109, all residents, when admitted to the home were identified to have a targeted fluid intake goal of 1500 mls a day until they were assessed by the RD and an individualized goal was determined.

According to the clinical record resident #002 was admitted to the home in October 2018.
Prior to their assessment by the RD the resident only met their fluid target goal of 1500 mls, on one occasion, according to the documentation on the Dietary Report.
A written referral was submitted to dietary services on a specific date in November 2018, following a meeting where it was identified that the resident required specific foods to eat due to their intake of food and fluids.
The RD assessed the resident on a specific date in November 2018, for their initial assessment and related to the referral. According to the records they were identified to be at nutritional risk with a fluid target goal of less than 1500 mls a day and prescribed an intervention to be administered.
According to the Dietary Records the resident did not meet their fluid target goal in December 2018, with the exception of on four identified dates, two of which were consecutive, and continued with poor intake of food at times.
There were no documented referrals included in the clinical record as submitted

to dietary services for December 2018, related to food and fluid intake; however, a written referral was submitted in December 2018, due to an area of altered skin integrity.
On a specific date in January 2019, a written referral was submitted to dietary services based on a discussion with the substitute decision maker (SDM).
The RD assessed the resident four days later for the referrals related to altered skin integrity as well as the discussion with the SDM.
The RD's documented assessment included a review of the food and fluid intake records and resulted in a revision to the plan of care to increase the intervention provided and included an additional intervention.
Despite the additional interventions the resident did not achieve their desired fluid target, according to the Dietary Reports, for a specific period of time and they continued with poor intake of food; however, no written referrals were included in the clinical record as submitted to dietary services.
The resident did not achieve their targeted fluid intake, according to the Dietary Reports, for two additional time periods and there was no documentation of referrals submitted to dietary services.
According to the clinical record in early February the resident had a change in their condition and on a specific date a referral was submitted noting a temporary change in diet texture and fluid consistency.
Interview with RN #109 following a review of information obtained from Dietary Reports confirmed that referrals should have been submitted due to documented intake.
Interview with the RD confirmed that dietary services received four referrals in total for the resident since their admission related to nutritional care and following a review of the Dietary Reports noted a pattern of poor intake of both food and fluids.

The policy and procedure was not complied with.

C. In accordance with O. Reg. 79/10, s. 68, the licensee was required to ensure that the nutrition care program included a weight monitoring system to measure and record the weight of each resident on admission and monthly thereafter and body mass index, and height upon admission and annually thereafter.

Specifically, staff did not comply with the licensee's policies and procedures regarding Monitoring of Resident Weights, LTC-RCM-G-20.80, effective January 2015, which identified that "all residents will be weighed and all weights will be recorded within 48 hours of admission and monthly thereafter" and regarding

Height Measurement, LTC-RCM-G-20.90, effective January 2015, which identified that "a resident's height will be taken upon admission and annually and whenever there is a significant change in height to determine the ratio between height and weight as related to dietary requirements and for calculation of Residents' individual Creatinine Clearance".

i. Resident #002 was admitted to the home in October 2018.
A review of the clinical record included progress notes on two dates in November 2018, by the RD that the admission height and weight had not yet been obtained.
Interview with the RD confirmed a delay in the completion of the admission nutritional assessment as the height and weight was not available.
A weight and height was recorded in the progress notes on a specific date in November 2018.
Interview with PSW #115 identified that admission height and weight was typically obtained on the date of admission on the evening shift.

ii. According to the clinical records resident #004 was admitted to the home in October 2018.
A review of the clinical record identified that the resident's height and weight was obtained on a specific date in November 2018.
Interview with RPN #117 verified that the resident's height and weight were obtained approximately two weeks after their admission to the home following a review of the clinical record.

The policies and procedures were not complied with.

D. In accordance with O. Reg. 79/10, s. 114, the licensee was required to ensure that written policies and procedures were developed for the medication management system.

Specifically, staff did not comply with the licensee's policy, provided by their pharmacy, related to Documentation of PRN (as needed) Medications, 4.11, with a revised date of August 2018, which identified following the administration of a PRN medication "a progress note is documented and includes the following: resident assessment, reason for medication administered, medication dose and time" and "PRN administration is entered on the MAR/eMAR indicating the time of administration and the dose/amount given if there is a range dose indicated by the Prescriber's order."

Resident #002 had an order for a medication to be administered routinely in addition to twice a day PRN (as needed).
A review of the eMAR and progress notes was completed and the following was identified:
i. A progress note on a specific day shift in November 2018, by RPN #106, identified that the resident was administered a PRN dose of the medication.
A review of the eMAR for the identified date and shift did not include documentation that the medication had been administered.
Interview with the RPN following a review of the available documentation verified that the medication was administered as documented on the progress notes but was, in an error of omission, not recorded on the eMAR.
ii. A progress note on a specific evening shift in December 2018, by RPN #108, identified that the resident was administered the medication. A review of the eMAR for the identified date and shift did not include documentation that the medication had been administered.
Interview with the RPN confirmed recollection that the medication was given as a PRN; however, that they may have forgotten to record the administration of the medication on the eMAR.

Not all records were consistent related to the administration time of the PRN medication, specifically:
i. According to the eMAR the medication was administered on a specific date in November 2018, at 0700 hours, by care provider #102. A review of the progress note at 0950 hours, by care provider #102, identified that the medication was administered; however, did not include the time of administration. A late entry the following day by RPN #106, at 0931 hours, who mentored the care provider, identified that the medication was administered at 1000 hours, on November 16, 2018.
ii. According to the eMAR the medication was administered on a specific date in November 2018, at 0954 hours, by care provider #102. A review of the progress notes, by care provider #102, recorded at 0955 hours, identified the administration of the medication. A progress note by RPN #106, at 1209 hours, who mentored the care provider, identified the administration time of administration to be 0900 hours.
iii. According to the eMAR the medication was administered on a specific date in November 2018, at 1043 hours, by RPN #106. A progress note for the same date at 1044 hours, noted the administration of the medication by RPN #106. A second progress note the same date by RPN #106, at 1410 hours, identified that the medication was administered at 1000 hours.

Interview with RPN #106 confirmed following a review of the clinical records, that the PRN medication was only administered once during the identified shifts; however, that the progress notes were not, in most cases, recorded at the same time as the eMAR, and that the eMAR would be the most accurate time of administration.

The policy and procedure was not complied with.

E. In accordance with O. Reg. 79/10, s. 30, the licensee was required to ensure that the program of falls prevention and management included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy and procedure Falls Prevention, LTC-RCM-G-30.00, with an effective date of January 2015, which identified under post fall assessment, the registered staff would "complete electronic post fall assessment by using the Post Fall Huddle or Fall incident report".
Hardy Terrace completed Post Fall Assessments manually, on paper, and not electronically according to the DOC.

The definition of a fall according to the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) was "any unintentional change in position where the resident ends up on the floor, ground or other lower level".

Resident #002 was identified at risk for falls according to the Resident Assessment Protocol (RAP) signed in November 2018.
A review of the progress notes for an identified date in January 2019, identified that the resident sustained a fall without injury at an identified time.
A subsequent note, the same day, identified that the resident was found in a position, approximately two hours later, and that they were assisted back into bed and settled.
A review of the clinical record did not include a post fall assessment for the second incident.
Interview with RN #118, who worked on the identified shift, confirmed that a post fall assessment was not conducted for the second incident, as they did not consider it a fall as the resident was not fully on the floor.
The DOC confirmed that they were not able to locate a post fall assessment, and following a review of the progress note of the second incident confirmed the

expectation that a post fall assessment be completed as required in the procedure.

The procedure was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have a policy and procedure, that the licensee was required to ensure that the policy and procedure was in compliance with applicable requirements under the Act.

O. Reg 79/10 s. 25(1)(a) required every licensee of a long term care home to ensure that, the assessments necessary to develop an initial plan of care under subsection 6(6) of the Act were completed within 14 days of the resident's admission.

i. The home had a procedure Resident Admission Nutrition - Hydration Assessment, DS-III-020, effective September 2014, which identified that "the dining services manager, gives the completed Part A form to the RD. The RD will complete Section K of MDS within 7 days of admission. If the RD is not available, Section K can be completed by the dining services manager or nursing. Within 21 days of admission, the Registered Dietitian will interview the resident, to complete the "Resident Admission Nutrition/Hydration Assessment".

The Resident Admission Nutrition/Hydration Assessment - Part B form was reviewed and was identified, by the FSM, to be completed by the RD on admission of a resident to the home.
The Assessment identified that the information was to be completed within 21 days of admission.
Interview with the RD identified that they attempted to complete an assessment within 14 days of admission to the home; however, that the process allowed for 21 days.

The procedure was not compliant with the legislation.

ii. A request was made of the DOC to provide a policy or written direction on the process to complete admission medicals, specifically the time frame for completion.
The DOC provided the policy and procedure Documentation - Resident Records, LTC-RCM-J-10.00, effective January 2015, which provided direction upon a

resident's admission to the home and included that the "interdisciplinary team members will completed all initial assessments as available in the electronic documentation system"; however, no time frame for completion was identified for the admission medical.
The DOC confirmed that the home did not have written documentation in place, specifically which provided direction related to the time frame to complete admission medicals.
Interview with the physician confirmed that all residents received a medical in the home yearly.

The procedure was not compliant with the legislation. [s. 8. (1) (a)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have a policy and procedure, that the licensee is required to ensure that the policy and procedure is in compliance with applicable requirements under the Act and is complied with, 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).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A. Resident #002 was on Dementia Observation System (DOS) monitoring. DOS documentation was completed for identified dates and time periods from October 2018, until February 2019.

DOS documentation, completed from specific dates in November 2018; and specific dates in January 2019; was reviewed and compared to the progress notes for the same time periods.

The comparison of the documentation identified that the assessments were not consistent with each other, specifically:
i. On an identified date in November 2018, DOS documentation during the night

shift identified no behaviours.
ii. The next date in November 2018, DOS documentation identified no concerns regarding the day and night shifts.
Progress notes documented on the night shift identified that for the past two nights the resident demonstrated a behaviour. Documentation on the day shift identified the resident demonstrated a behaviour.
iii. On an identified date in November 2018, DOS documentation identified no concerns during the night shift.
The progress notes included documentation during the night shift which identified that the resident demonstrated a behaviour.
iv. On an identified date in January 2019, DOS documentation during the evening shift identified no behaviours. Progress notes documented on the evening shift identified the resident demonstrated a behaviour.
v. On an identified date in January 2019, DOS documentation during the day shift identified no responsive behaviours.
A progress note documented on the day shift identified that the resident demonstrated a behaviour.

Interview with RN #110 confirmed that there was a process in place for the auditing of DOS records.
The RN was informed of a few of the examples identified above in the progress notes with the DOS records available for review.
The RN identified that although they were not aware of the specific examples provided, confirmed that they were aware that the records were not always consistent with each other.

B. Resident #004 had Dementia Observation System (DOS) documentation completed for a period of seven days.
A review of the documentation did not include the presence of behaviours.
A review of the clinical record included a progress note, during the seven day time period, which identified that the resident demonstrated a behaviour.
Interview with RN #110 verified that they recalled the incident and on review of the DOS records this information was not present.

The assessments were not consistent with and did not complement each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

According to the progress notes resident #002 sustained a fall on an identified date in December 2018, and a message was left for the physician regarding the fall on the "doctor's board".
A progress note written, by the physician, the following day, for the day prior, identified the fall and provided direction to hold a medication.
A review of the electronic Medication Administration Record (eMAR) for December 2018, did not identify that the medication was held as prescribed.
Following a review of the identified progress notes and the eMAR, the RAI Coordinator and the DOC confirmed that the medication was not held as requested by the physician.

Care was not provided as specified in the plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan 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 effective.

A. Resident #002 was observed on a specific date in February 2019, in a specific condition, with specific care needs and according to the clinical record had a diagnosis two days prior.
During the course of the inspection the resident continued to have a change in condition.
According to the progress notes, on a specific date in February 2019, following a discussion with the substitute decision maker (SDM), the the resident was to be provided a specific level of care.

A review of the plan of care, in place on a specific date in February 2019, which was dated six days prior did not include changes in the resident's care needs, some specific examples included related to:
i. The use of a specific intervention.
The plan did not include the use of the intervention, which was observed to be in use in February 2019.
ii. Specific responsive behaviours currently displayed and interventions required to manage them. The plan identified that the resident demonstrated behaviours which were no longer behaviours currently in place for the resident according to a review of the clinical record and discussion with the DOC.
iii. The plan identified that the resident had specific nutritional care interventions

and provided conflicting statements on diet and fluid textures.
According to the clinical record the resident was at nutritional risk and was on interventions to promote gradual weight gain. The resident was observed on a specific date in February 2019, to receive an intervention and had difficulty completing a task.
RN #109, following a review of the plan of care confirmed that the plan had not been updated with the recent changes in the care needs and status of the resident.

The resident's plan of care was updated during the time of the inspection, with the next archived plan of care dated one week later.
The plan of care was not reviewed and revised with changes in the resident's care needs, some specific examples included:
i. The plan noted that the resident was to receive specific care twice a day, was resistant to the care and for staff to encourage the resident to assist as able. During the inspection, PSW staff were observed to provide the care, without resistance. Staff reported an increase in the frequency of care provided.
ii. The plan did include the presence of altered skin integrity; however, did not provide direction on the need to and frequency of specific care, care which was observed to be provided by PSW staff during the inspection.
iii. The plan did not include the use of an intervention, which was observed to be in use during the inspection.
iv. The plan identified that the resident demonstrated behaviours, which according to observations and the clinical record did not occur during the time period of the inspection.
v. The plan identified that the resident required a level of care and interventions specific to some activities of daily living. This information was not reflective of the care needs, according to observations and the clinical record during the time period of the inspection.

RN #125 identified that they were in the process of revising the plan of care to reflect the current needs of the resident, the following day.

B. According to the clinical record, on a specific date in December 2018, resident #007 had a change in condition.
Following treatment for the change in condition the resident had a number of changes in their care requirements.
A review of the plan of care, dated January 2019, did not include all of the changes in care needs as documented in the clinical record specifically:

i. the resident had a change in direction, in December 2018; however, the plan of care still provided the previous directions.
ii. orders were received from the physician that medications were to be administered by a specific route; however, the plan noted that medication was to be administered by the route only if another option was not successful.

Interview with the DOC following a review of the clinical record, confirmed that the plan of care was not revised when care needs changed.

C. Resident #008 had a change in condition and as a result an intervention was provided for a specific period of time starting on a specific date in February 2019.
A review of the most recent plan of care, dated the day of the intervention, was completed.
When the plan of care was reviewed later in February 2019, it was noted that it was not reviewed and revised with changes in the resident's care needs, specifically it did not include the use of the intervention.
The plan also noted that the resident had two different targeted fluid intake requirements in two different focus statements.
Interview with RN #109 identified that all resident's were identified to have a targeted fluid requirement of 1500 mls, on admission, until the RD assessed the resident, at which time the target would be changed to the individual assessed need.
Interview with the DOC following a review of the clinical record, confirmed that the plan of care was not revised with a change in care needs.

The plan of care was not reviewed and revised with changes in the resident's care needs. [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan was not effective.

Resident #002 was identified at a risk for falls according to the Resident Assessment Protocol signed in November 2018.
A review of the progress notes identified that the resident had multiple falls from October 2018, until January 2019.
A review of the plan of care in place on a specific date in December 2018, and on a specific date in February 2019, identified the risk for falls.
The current interventions in place on both plans of care included the same

interventions.
The more recent plan, was created following subsequent falls since December 2018, and did not include any new interventions in an effort to manage the risk when previous interventions were not effective.
Interview with RN #110, following a review of the plan of care dated in February 2019, confirmed that the plan of care had not been consistently revised when the care set out in the plan had not been effective related to falls.

The resident was not reassessed and the plan of care revised at least every six months and at any other time when care set out in the plan was not effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002 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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments, are integrated, consistent with and complement each other and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to 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 care set out in the plan is not effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act were completed within 14 days of the resident's admission.

A. According to the clinical record resident #002 was admitted to the home in October 2018.
i. A review of the clinical record included a progress note from the physician dated on a specific date in February 2019, which indicated that the physical assessment and medication review had been completed.
The chart included a Medical Assessment - Admission/Annual Physical Exam form signed as completed in February 2019.
Interview with the RAI Coordinator following a review of the clinical record verified that the assessment was completed in February 2019.
ii. A review of progress notes on two dates in November 2018, identified that the RD could not complete an assessment of the resident, as their admission height and weight had not yet been obtained and requested that these assessments be completed.
The chart included a Resident Admission Nutrition/Hydration Assessment - Part B form signed as completed by the RD on a specific date in November 2018.
Interview with the RD confirmed that there was a delay in the completion of the admission assessment due to the delay in obtaining all relevant information regarding the resident.

B. According to the clinical records resident #004 was admitted to the home on a specific date in October 2018.
A review of the Resident Admission Nutrition/Hydration Assessment - Part B identified that the assessment was signed as completed by the RD on a specific date in November 2018.
Interview with RPN #117 confirmed that the Resident Admission Nutrition/Hydration Assessment - Part B was signed as completed on a specific date in November 2018.

The assessments necessary to develop and initial plan of care were not completed within 14 days as required. [s. 25. (1) (a)]

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 assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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

Findings/Faits saillants :

(A2)
1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act, a written record relating to each evaluation under paragraph 3 that included a summary of the changes made and the date that those changes were implemented.

On request the DOC provided the Annual Program/Service Evaluation for the Dietary Hydration Program.
The Evaluation was reviewed and identified three goals for the program for 2018.

The Evaluation included changes made to achieve one of the three goals. Interview with the FSM identified that changes were made to achieve the other two goals; however, that this was not documented on the Evaluation or formally recorded in another location and no dates of the changes were available.

The licensee did not keep a written record, related to the evaluation of the required program, dietary services and hydration, that included a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 4.]

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

A. Resident #002 was identified at a nutritional risk.
A review of the Dietary Reports, a record of the food and fluid intake of a resident, used to assist in the assessment process, was completed.
The reports did not consistently include documentation of the response of the resident to the interventions, specifically the amount of food or fluid consumed, if any, at a meal or nourishment pass.
For the period of time between a specific date in October 2018, until a specific date in February 2019, there were 13 occasions where the amount consumed during a nourishment pass was not documented and six occasions where intake at a meal was not documented.

B. Resident #017 was identified at a nutritional risk.
A review of the Dietary Reports, a record of the food and fluid intake of a resident, used to assist in the assessment process, was completed.
The reports did not consistently include documentation of the response of the resident to the interventions, specifically the amount of food or fluid consumed, if any, at a meal or nourishment pass.
For the period of time between a specific date in January 2019, until a specific date in February 2019, there was one occasion where the amount consumed at a nourishment pass was not documented and one occasion where intake at a meal was not documented.

Not all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

A. Resident #002 had a Resident Assessment Protocol, signed as completed in November 2018, which identified that the resident was at risk for pressure ulcers. According to the clinical record the resident was transferred to the hospital on a specific date in January 2019 and returned the following day.
A review of the clinical record did not include a skin assessment by a member of the registered nursing staff on return from hospital.
Interview with the DOC, following a review of the record verified that a skin assessment was not completed on return from hospital.

B. According to the clinical records resident #008 was identified in their Pressure Ulcer Risk Scale, dated in October 2018, at risk for pressure sores.
The clinical record identified that they were transferred to the hospital on a specific date in January 2019, and returned the following day.
A review of the clinical record did not include a skin assessment, by a member of the registered nursing staff, upon return from hospital.
Interview with RN #110, following a review of the clinical record, confirmed that the skin assessment was not completed.

A skin assessment was not completed as required on return from the hospital. [s. 50. (2) (a) (ii)]

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 a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident who demonstrated responsive behaviours that actions were taken to respond to the needs of the resident, including assessment, reassessments and interventions and the resident's responses to interventions were documented.

Resident #002 was on Dementia Observation System (DOS) monitoring due to the presence of responsive behaviours and the use of a medication.
DOS documentation was completed from specific dates and times from October 2018 until February 2019.
DOS documentation, completed for specific dates in November 2018 and January 2019, was reviewed and compared to the progress notes for the same time periods.
A review of the documents did not consistently include that interventions and the resident's responses to interventions were documented.
The documentation identified the following:

i. On a specific date in November 2018, DOS documentation during the day shift identified that the resident demonstrated behaviours.
There was no documentation in the progress notes related to responsive behaviours on the day shift, nor specific interventions attempted or the resident's response.
ii. The following day, DOS documentation during the day and evening shift identified the presence of behaviours.
There was no documentation in the progress notes related to responsive behaviours on the day or evening shift, nor specific interventions attempted or the resident's response.
iii. The next day, DOS documentation and progress notes identified the presence of behaviours during the day shift; however, the only interventions identified were related to refusal to attend and complete an activity and that the resident would continue to be monitored.
DOS documentation during the evening shift identified the presence of a behaviour.
There was no documentation in the progress notes on the evening shift regarding behaviours, specific interventions attempted or the resident's response.
iv. The next day, DOS documentation and progress notes identified the presence of a behaviour; however, there was no documentation related to specific interventions attempted or resident's response.
v. The following day, DOS documentation identified behaviours during the evening shift; however, there was no documentation in the progress notes related to the responsive behaviours on the evening shift, nor specific interventions attempted and the resident's response.
vi. On a specific date, in January 2019, DOS documentation identified during the night shift that the resident demonstrated a specific behaviour.
Progress notes included the presence of the behaviour; however, did not include specific interventions attempted, aside from family notification, nor the resident's response.
vii. The following day, DOS documentation identified during the day shift that the resident demonstrated a behaviour and the progress notes identified the behaviour.
The record did not include specific interventions attempted, aside from ongoing monitoring, nor the resident's response.
viii. On a specific date, in January 2019, DOS documentation identified during the day shift, before lunch, that the resident displayed a behaviour.
There was no documentation of the behaviour in the progress notes nor specific interventions attempted.

Progress notes did identify that the resident was provided care by staff, lunch intake and activities post eating.

Interview with RN #110 confirmed that there was a process in place for the auditing of DOS records.
The RN was informed of a few of the examples identified above in the progress notes with the DOS records available for review.
The RN identified that although they were not aware of the specific examples provided, confirmed that based on the records reviewed that the records did not include interventions and the resident's response.

For the resident who demonstrated responsive behaviours documentation did not consistently include that actions were taken to respond to the needs of the resident, including assessment, reassessments and interventions and the resident's responses to interventions documented. [s. 53. (4) (c)]

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 for each resident who demonstrates responsive behaviours that actions are taken to respond to the needs of the resident, including assessment, reassessments and interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 70. Administrator

Specifically failed to comply with the following:

s. 70. (1) Every licensee of a long-term care home shall ensure that the home has an Administrator. 2007, c. 8, s. 70. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had an Administrator.

Interview with the DOC identified that they were currently acting in the role of Administrator of the home in addition to their responsibilities for the nursing department as the DOC.
The DOC identified that the previous Administrator left the position on a specific date in January 2019.
The DOC identified that they did not possess the qualifications of an Administrator.

The home did not have an Administrator. [s. 70. (1)]

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 home has an Administrator, to be implemented voluntarily.

WN #8: 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, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was offered a minimum of a beverage in the morning, afternoon and a beverage in the evening after dinner and to ensure that each resident was offered a minimum of, a snack in the afternoon and evening.

Interview with the DOC identified that when an "O" was recorded on the Dietary Report this indicated that the item was "not offered" and the expectation of staff to attempt to rouse a resident who was asleep to offer nourishment.

A. Resident #002 was identified at a nutritional risk according to the plan of care, which included the preference of the resident to sleep in later in the morning.
A review of the Dietary Reports from a specific date in October 2018, until a specific date in February 2019, identified that the resident was not offered a snack on thirteen occasions.

B. Resident #008 was identified at a specific risk per the plan of care.
On a specific date in February 2019, the resident was not offered a between meal beverage in the morning, until a request was made by the Inspector to PSW #123, at 1059 hours.
The PSW identified that they did not provide the beverage to the resident earlier as they were asleep and communicated their plan to offer the beverage at a later time.
The PSW was observed to enter the room, at 1059 hours, with a beverage for the resident.
A review of the Dietary Report from a specific date in January 2019, until a specific date in February 2019, identified that the resident was not offered a between meal beverage on one occasion and a snack on three occasions.

C. Resident #017 was identified at a nutritional risk in their plan of care which included direction from the substitute decision maker related to sleep and rest routines.
A review of the Dietary Report from a specific date in January 2019, until a specific date in February 2019, identified that the resident was not offered a snack on eight occasions.

There were a number of dates recorded during the identified time periods that noted that one or more of the residents were "S" sleeping or "D" declined nourishment and meals.

Interview with the DOC following a brief review of the Dietary Reports for the three residents confirmed that according to the documentation it appeared that residents were not consistently offered nourishment as required. [s. 71. (3) (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 resident is offered a minimum of a beverage in the morning, afternoon and a beverage in the evening after dinner and to ensure that each resident is offered a minimum of, a snack in the afternoon and evening, to be implemented voluntarily.

Issued on this 3 rd day of April, 2019 (A2)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LISA VINK (168) - (A2)
Inspection No. / No de l'inspection :	2019_556168_0006 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	018917-18, 002010-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 03, 2019(A2)
Licensee / Titulaire de permis :	Diversicare Canada Management Services Co., Inc. 2121 Argentia Road, Suite 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	Hardy Terrace 612 Mount Pleasant Road, R.R. #2, BRANTFORD, ON, N3T-5L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Rooyakkers

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Diversicare Canada Management Services Co., Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s 8(1)b of Ontario Regulation 79/10.

Specifically the licensee must:
A. Review their policy and procedure Referral to Dietitian and or Director of Dietary Services, LTC-NAM-E-10.10, effective date January 2015, to ensure that it is up to date and reflective of the expectations of the licensee. Revisions shall be made to the policy and procedure as appropriate.
B. Provide training to all nursing staff regarding the policy and procedure and expectations including: assessments to be completed, how to complete the assessments and when and how to submit a referral to dietary services.
C. Comply with their policy and procedure Referral to Dietitian and or Director of Dietary Services, LTC-NAM-E-10.10.
D. Develop and implement an auditing process to ensure that staff are following the policy and procedure, to be completed at times and frequencies as determined by the home. Records of the audits and actions taken shall be maintained.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home have, institute or otherwise put in place any policy, procedure and protocol, that the policy, procedure and protocol was complied with.

In accordance with O Reg 79/10, s. 68, the licensee was required to have a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the licensee's policy and procedure Referral to Dietitian and or Director of Dietary Services, LTC-NAM-E-10.10, effective date January 2015, which identified to "assess all residents for nutritional risk factors and determine if RD referral is necessary in cases such as: unplanned inadequate food intake/appetite experienced for three or more days; food consistently less than 50% consumed at and between meals and poor fluid intake over a 72 hour period and exhibits signs and symptoms of dehydration".

i. According to the plan of care, resident #008 was identified at specific risk, received an intervention and was assessed by the RD for a fluid goal target of a specific number of milliliters (mls) a day.
A review of the Point of Care (POC) records, progress notes and the eMAR identified that since the last assessment by the RD, on a specific date in January 2019, the resident did not consistently achieve their targeted fluid goal.
Fluid intakes were combined as recorded in POC and on the eMAR.
The resident was documented below their targeted fluid intake for periods of 72 hours or greater on three dates in January and February 2019.
A review of the clinical record did not include any referrals for the resident's low fluid intake in January or February 2019.
Interview with the FSM identified that they were unaware of any recent referrals for the resident related to hydration, following a review of the POC records.
A review of the progress notes did not include any assessments of the resident related to signs and symptoms of dehydration for the period of time between the identified dates.
According to the progress notes the resident experienced a change in condition and was assessed on a specific date in February 2019, at which time an intervention was initiated for a period of time, along with additional measures.
Interview with the DOC, following a review of POC records confirmed that according to the policy it was the expectation that a referral was submitted to dietary services.

ii. According to the plan of care, resident #017 was identified at nutritional risk and was assessed by the RD for a fluid goal target of a specific number of mls a day.

A review of the POC records and progress notes identified that since the last assessment by the RD, on a specific date in January 2019, the resident did not consistently achieve their targeted fluid goal.
The resident was documented below their targeted fluid intake for a period of 72 hours on one occasion in February 2019.
A review of the clinical record did not include any referrals for the resident's low fluid intake in February 2019.
Interview with the FSM identified that they were unaware of any recent referrals for the resident related to hydration, following a review of the POC records.
A review of the progress notes did not include any assessments of the resident related to signs and symptoms of dehydration for the period of time identified.
Interview with the DOC, following a review of POC records confirmed that according to the policy it was the expectation that a referral was submitted to dietary services.

iii. According to RN #109, all residents, when admitted to the home were identified to have a targeted fluid intake goal of 1500 mls a day until they were assessed by the RD and an individualized goal was determined.

According to the clinical record resident #002 was admitted to the home in October 2018.
Prior to their assessment by the RD the resident only met their fluid target goal of 1500 mls, on one occasion, according to the documentation on the Dietary Report.
A written referral was submitted to dietary services on a specific date in November 2018, following a meeting where it was identified that the resident required specific foods to eat due to their intake of food and fluids.
The RD assessed the resident on a specific date in November 2018, for their initial assessment and related to the referral. According to the records they were identified to be at nutritional risk with a fluid target goal of less than 1500 mls a day and prescribed an intervention to be administered.
According to the Dietary Records the resident did not meet their fluid target goal in December 2018, with the exception of on four identified dates, two of which were consecutive, and continued with poor intake of food at times.
There were no documented referrals included in the clinical record as submitted to dietary services for December 2018, related to food and fluid intake; however, a written referral was submitted in December 2018, due to an area of altered skin integrity.
On a specific date in January 2019, a written referral was submitted to dietary

services based on a discussion with the substitute decision maker (SDM).
The RD assessed the resident four days later for the referrals related to altered skin integrity as well as the discussion with the SDM.
The RD's documented assessment included a review of the food and fluid intake records and resulted in a revision to the plan of care to increase the intervention provided and included an additional intervention.
Despite the additional interventions the resident did not achieve their desired fluid target, according to the Dietary Reports, for a specific period of time and they continued with poor intake of food; however, no written referrals were included in the clinical record as submitted to dietary services.
The resident did not achieve their targeted fluid intake, according to the Dietary Reports, for two additional time periods and there was no documentation of referrals submitted to dietary services.
According to the clinical record in early February the resident had a change in their condition and on a specific date a referral was submitted noting a temporary change in diet texture and fluid consistency.
Interview with RN #109 following a review of information obtained from Dietary Reports confirmed that referrals should have been submitted due to documented intake.
Interview with the RD confirmed that dietary services received four referrals in total for the resident since their admission related to nutritional care and following a review of the Dietary Reports noted a pattern of poor intake of both food and fluids.

The policy and procedure was not complied with.

The severity of this issue was determined to be a level 2 as there was the potential for actual harm to the residents.
The scope of this issue was a level 3 as it was widespread and related to 3 of 3 residents.
The home had a level 3 compliance history with this section of the LTCHA that included:
-voluntary plan of correction (VPC) November 21, 2017, report 2017-695156-0002. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 24, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Order / Ordre :

The licensee must be compliant with s. 6(10) of the LTCHA.

Specifically the licensee must:
A. Review and revise the plans of care for residents #007 and #008 and any other resident, who has had a change in their care needs or when the care set out in the plan is no longer necessary.
B. Create a plan to ensure that when a resident has had a change in their condition the plan of care is reviewed and revised. The plan shall include who is responsible to review and revise the plans of care and the expected time frame for completion of the revisions.
C. Develop a process to audit plans of care following a change in condition to ensure that the plans are reviewed and revised as required. The home shall determine the frequency of auditing; however, shall maintain records of the auditing completed and actions taken as a result.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was reassessed and the plan 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 effective.

A. Resident #002 was observed on a specific date in February 2019, in a specific condition, with specific care needs and according to the clinical record had a diagnosis two days prior.
During the course of the inspection the resident continued to have a change in condition.
According to the progress notes, on a specific date in February 2019, following a discussion with the substitute decision maker (SDM), the the resident was to be provided a specific level of care.

A review of the plan of care, in place on a specific date in February 2019, which was dated six days prior did not include changes in the resident's care needs, some specific examples included related to:
i. The use of a specific intervention.
The plan did not include the use of the intervention, which was observed to be in use in February 2019.
ii. Specific responsive behaviours currently displayed and interventions required to manage them. The plan identified that the resident demonstrated behaviours which were no longer behaviours currently in place for the resident according to a review of the clinical record and discussion with the DOC.
iii. The plan identified that the resident had specific nutritional care interventions and provided conflicting statements on diet and fluid textures.
According to the clinical record the resident was at nutritional risk and was on interventions to promote gradual weight gain. The resident was observed on a specific date in February 2019, to receive an intervention and had difficulty completing a task.
RN #109, following a review of the plan of care confirmed that the plan had not been updated with the recent changes in the care needs and status of the resident.

The resident's plan of care was updated during the time of the inspection, with the next archived plan of care dated one week later.
The plan of care was not reviewed and revised with changes in the resident's care needs, some specific examples included:
i. The plan noted that the resident was to receive specific care twice a day, was resistant to the care and for staff to encourage the resident to assist as able.
During the inspection, PSW staff were observed to provide the care, without resistance. Staff reported an increase in the frequency of care provided.
ii. The plan did include the presence of altered skin integrity; however, did not

provide direction on the need to and frequency of specific care, care which was observed to be provided by PSW staff during the inspection.
iii. The plan did not include the use of an intervention, which was observed to be in use during the inspection.
iv. The plan identified that the resident demonstrated behaviours, which according to observations and the clinical record did not occur during the time period of the inspection.
v. The plan identified that the resident required a level of care and interventions specific to some activities of daily living. This information was not reflective of the care needs, according to observations and the clinical record during the time period of the inspection.

RN #125 identified that they were in the process of revising the plan of care to reflect the current needs of the resident, the following day.

B. According to the clinical record, on a specific date in December 2018, resident #007 had a change in condition.
Following treatment for the change in condition the resident had a number of changes in their care requirements.
A review of the plan of care, dated January 2019, did not include all of the changes in care needs as documented in the clinical record specifically:
i. the resident had a change in direction, in December 2018; however, the plan of care still provided the previous directions.
ii. orders were received from the physician that medications were to be administered by a specific route; however, the plan noted that medication was to be administered by the route only if another option was not successful.

Interview with the DOC following a review of the clinical record, confirmed that the plan of care was not revised when care needs changed.

C. Resident #008 had a change in condition and as a result an intervention was provided for a specific period of time starting on a specific date in February 2019.
A review of the most recent plan of care, dated the day of the intervention, was completed.
When the plan of care was reviewed later in February 2019, it was noted that it was not reviewed and revised with changes in the resident's care needs, specifically it did not include the use of the intervention.

The plan also noted that the resident had two different targeted fluid intake requirements in two different focus statements.
Interview with RN #109 identified that all resident's were identified to have a targeted fluid requirement of 1500 mls, on admission, until the RD assessed the resident, at which time the target would be changed to the individual assessed need.
Interview with the DOC following a review of the clinical record, confirmed that the plan of care was not revised with a change in care needs.

The plan of care was not reviewed and revised with changes in the resident's care needs. [s. 6. (10) (b)]

The severity of this issue was determined to be a level 2 as there was the potential for actual harm to the residents.
The scope of this issue was a level 3 as it was widespread and related to 3 of 3 residents.
The home had a level 4 compliance history with this section of the LTCHA that included:
-voluntary plan of correction (VPC) September 26, 2016, report 2016-275536-0014;
-VPC November 21, 2017, report 2017-695156-0002; and
-VPC March 21, 2018, report 2018-558123-0007. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 24, 2019

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 3 rd day of April, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by LISA VINK (168) - (A2)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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