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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2014	2014_235507_0003	T-49-14	Resident Quality Inspection

Licensee/Titulaire de permis

KRISTUS DARZS LATVIAN HOME
11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6

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

KRISTUS DARZS LATVIAN HOME
11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6

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

STELLA NG (507), JOELLE TAILLEFER (211), SUSAN SEMEREDY (501), SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 12, 13, 14, 18, 19, 20 and 21, 2014.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), Resident Assessment Instrument (RAI) coordinator, registered dietitian (RD), nutrition services manager (NSM), physiotherapist (PT), registered nursing staff, facility manager, personal support workers(PSWs), maintenance staff, housekeeping staff, resident services coordinator, substitute decision makers, residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, completed record reviews for identified residents and staff, observed dining and snack service, observed medication administration, observed resident and staff interactions, reviewed the licensee's policies, reviewed meeting minutes for Resident Council.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

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 failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to residents.

Clinical record review and staff interviews confirmed that resident #211's plan of care did not specify the location and the intervention of the resident's dressing. Staff interviews revealed that the resident's identified dressing was only changed as needed.

Resident observation revealed that resident #198 had a skin breakdown. Clinical record review and staff interview confirmed that the resident's plan of care did not specify the location and intervention of the resident's skin breakdown.

Clinical record review revealed that the status of resident #190's pressure ulcer was unclear. Staff interview confirmed that resident #190's plan of care did not specify the stage, the type and the location of the pressure ulcer. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #175 experienced pain on a daily basis and was on weekly pain assessment. Staff interview revealed that medication and exercise were interventions for pain management for the resident. Record review and staff interview confirmed that the resident was receiving daily narcotic analgesic.

The home's pain management program states one of the roles and responsibilities of registered nursing staff is to make a referral to the interdisciplinary team members in pain management. Interview with the PT revealed that a referral for this resident was not received even though exercise was identified as one of the interventions for pain management. [s. 6. (4) (a)]

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

On an identified date, the inspector observed in the small dining room during the lunch meal that resident #301 was served regular textured apricots for dessert. Record review and staff interviews confirmed that the resident should have been served minced textured apricots as per his/her plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, to ensure that staff and others involved in the different aspects of care 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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Record review revealed that the policy titled Weights (LTC-006) dated December 2013, states that all residents will be weighed on admission and monthly thereafter. Record review and staff interviews revealed that resident #241 was not weighed upon return from hospital, or in the month after. Staff interviews confirmed that possible weight change with negative outcomes would not have been identified until two months after return from hospital.

Record review and staff interviews revealed that resident #211 was in isolation for an infectious condition and was to have contact precautions in place. Review of the infection prevention and control manual, section 2.0 routine and additional precautions, reviewed in January of 2013, revealed that contact precautions for this infectious condition includes signage to alert staff and visitors outside of resident rooms. Inspectors observed that signage was not posted outside of resident #211's room on identified dates. Staff interviews confirmed that signage should have been posted. [s. 8. (1)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Review of the policy titled Weights (LTC-006) dated December 2013, revealed that weight loss or gain of 2-5% of total body weight over 1 month or 5-7% over a 3 month period requires interventions. The policy does not indicate that a change of 10 per cent of body weight, or more, over 6 months requires assessment, actions taken and outcomes evaluated as per O.Reg. 79/10 section 69 (4). Staff interviews confirmed that this policy needs to be updated. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, and is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

According to Health Canada document entitled Adult Hospital Beds: potential entrapment hazard, siderail latching reliability and other hazards (2008) to reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head to be trapped. A head breadth dimension of 120 mm (4 -3/4inches) is used as the basis for its dimensional limit recommendations. Zone seven includes the area between the head or foot board and the mattress end.

Measurement of the area in zone seven for resident #203 indicates that there is a 5-1/2 " gap between the mattress and the headboard of the bed. Measurements of the area in zone seven for resident #198 indicates that there is a 7-1/4" gap between the headboard of the bed and the mattress.

On June 2013, the licensee had Shoppers Home Health Care conduct an audit on the entrapment zones for the beds in the home. Recommendations were left for the home to consider replacing the mattress inventory because the mattresses are shorter than the 84" bed frames. The audit recommended that the home also consider replacing the inventory of MC Healthcare Beds because they failed zone three test which is the area between the rail and the mattress. Furthermore, as indicated on the audit results report dated June 17, 2013, a bed frame with a therapeutic air mattress was not tested by Shoppers at that time. [s. 15. (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 steps are taken to prevent resident entrapment, taking into consideration of all potential zones of entrapment, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
A change of 5 per cent of body weight, or more, over one month
A change of 7.5 per cent of body weight, or more, over three months
A change of 10 per cent of body weight, or more, over 6 months

Record review revealed that resident #203 had a weight loss of 16.4% (11.3 kg) over one-month period. Staff interviews confirmed that this weight change was not assessed.

Record review revealed that resident #190 had a weight loss of 10.1% (5.6 kg) over a six-month period, and weight loss of 7.7% (4.1 kg) over a three-month period. Staff interviews confirmed that this weight change was not assessed. [s. 69.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
A change of 5 per cent of body weight, or more, over one month,
A change of 7.5 per cent of body weight, or more, over three months, and
A change of 10 per cent of body weight, or more, over 6 months, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to address incidents of lingering offensive odours.

There was a strong lingering odor of urine present from February 12 to 20, 2014, on the second floor. The odour affected most of the resident rooms and areas along the east corridor and was apparent inside of the bedrooms located directly across the hall.

Staff interview revealed that the odour has been present for quite some time and the home is unable to determine how they will address the odour. [s. 87. (2) (d)]

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 address incidents of lingering offensive odours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (1) The licensee shall ensure that there is a designated lead for each of the housekeeping, laundry services and maintenance services programs, but the same person may be the designated lead for more than one program. O. Reg. 79/10, s. 92 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a designated lead for the housekeeping, laundry, and maintenance.

Staff interview indicated that there is currently no designated lead for the home's housekeeping, laundry, and maintenance program in the home. [s. 92. (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 there is a designated lead for the housekeeping, laundry, and maintenance, 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 failed to ensure that the drugs stored in the emergency medication box complies with the manufacture's instruction for the storage of the drugs related to the expiration dates.

Staff interview and observation of the emergency medication box revealed that the prochlorperazine ampoules, the prednisone tablet medication's dates were expired since January 2014 and the moxifloxacin tablet medication ordered for an identified resident on January 13, 2014 did not have an expiry date on the package. [s. 129. (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 drugs stored in the emergency medication box complies with the manufacture's instruction for the storage of the drugs related to the expiration dates, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 132. Natural health products

Specifically failed to comply with the following:

s. 132. (1) Every licensee of a long-term care home shall ensure that where a resident wishes to use a drug that is a natural health product and that has not been prescribed, there are written policies and procedures to govern the use, administration and storage of the natural health product. O. Reg. 79/10, s. 132 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's natural health product policy is followed where a resident wishes to use a drug that is a natural health product and that has not been prescribed.

Resident #301 was observed self administering an identified natural health product at lunch time on an identified date.

Resident interview confirmed that he/she was self-administering an identified natural health product daily. Record review and staff interview confirmed that resident #301 did not have a prescription for any natural health product, and staff were not aware the resident was taking any natural health product. The home's natural health product policy states if the resident is to self-administer the natural health product, the physician is required to write an order for the natural health product, and indicating the resident can self-administer. [s. 132. (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's natural health product policy is followed where a resident wishes to use a drug that is a natural health product and that has not been prescribed, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

Record review and staff interviews revealed that resident #211 was in isolation for an infectious condition which required contact precautions. On an identified date, staff were observed to reposition resident in bed without donning a gown for contact precautions even though personal protective equipment was available outside of the room. Staff interviews confirmed that a gown should have been worn for this procedure. [s. 229. (4)]

2. The licensee failed to ensure that residents are offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

Record review and staff interview revealed the following:
Resident #232 was not offered immunization against pneumoccocus, tetanus and diphtheria.
Resident #228 and #240 were not offered immunization against tetanus and diphtheria.

Observation and staff interview confirmed that the home did not have tetanus or diphtheria vaccines in the building on February 18, 2014.
Note: The home has now implemented a policy for immunization in accordance with publicly funded immunization schedules. [s. 229. (10) 3.]

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 staff participate in the implementation of the infection prevention and control program, and to offer residents immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects this/her dignity.

Interview with resident #241 revealed that a PSW refused to assist the resident downstairs to the dining room. According to the resident, he/she was able to go downstairs for his/her meal but found it difficult that day due to pain. Interview with registered staff revealed the resident had reported this incident two weeks after it occurred and the resident could not recall the PSW's name. [s. 3. (1) 1.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment that includes the resident's nutritional status, height, weight and any risks relating to nutritional care.

According to record review resident #241 was hospitalized for two weeks. Record review and staff interviews revealed that the resident was not weighed upon return from hospital or in the following month. Staff interviews confirmed that the readmission plan of care for resident #241 did not include an assessment of weight. [s. 26. (3) 13.]

WN #12: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Clinical record review and staff interview confirmed that resident #198's skin breakdown did not receive a skin assessment. [s. 50. (2) (b) (i)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of Resident Council meeting minutes for November and December 2013 and January 2014 revealed that residents had concerns that staff were not always offering nourishments, towels are dropped on the bathroom floor and left there, staff talk amongst themselves instead of encouraging residents to eat in dining rooms, medications are not given at appropriate times, agency staff are unaware of procedures, staff are not always respectful to each other, desserts are served in disposable containers, floors in bedrooms are slippery, coffee and tea is not always hot, staff are sometimes abrupt and not polite, exercise programs are not intensive enough and food is not always acceptable.
Record review and interviews revealed that a response in writing within 10 days of receiving these concerns was not made. Staff interview revealed that staff address residents' concerns at the subsequent meetings. [s. 57. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration programs include the development of policies and procedures relating to nutrition care and dietary services and hydration, in consultation with a dietitian who is a member of the staff.

Review of the policy titled Weights (LTC-006) dated December 2013 revealed that weight loss or gain of 2-5% of total body weight over 1 month or 5-7% over a 3 month period requires interventions. The policy does indicate that a change of 10 per cent of body weight, or more, over 6 months requires assessment, actions taken and outcomes evaluated as per O.Reg. 79/10 section 69 (4). Staff interviews confirmed that this policy was not developed in consultation with a dietitian who is a member of the staff. [s. 68. (2) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.
Record review and interviews revealed that dining and snack service times are not reviewed by the Residents' Council. [s. 73. (1) 2.]

Issued on this 3rd day of March, 2014

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

on behalf of Stella Ng.