Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 26, 2020	2020_818502_0002 (A2)	022164-19	Follow up

Licensee/Titulaire de permis

United Counties of Prescott and Russell
59 Court Street Box 304 L'Orignal ON K0B 1K0

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

Residence Prescott et Russell
1020 Cartier Boulevard HAWKESBURY ON K6A 1W7

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

Amended by JULIENNE NGONLOGA (502) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

An extension of the compliance due date was granted due to the COVID-19 pandemic.

Issued on this 26th day of May, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by JULIENNE NGONLOGA (502) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 10 and 14, 2020.

The inspection relates to log #022164-19 related to a follow-up Compliance Order (CO) #001 from inspection # 2019_583117_0051.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Nursing Supervisor, the Food Service Supervisor, Registered Dietitian, Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs).

During the course of the inspection, the inspector reviewed identified resident's health care records, conduct dining room and snack observation, observed the provision of meal, snacks, and beverage, reviewed dietary beverage and snack menu, relevant policy and procedure.

The following Inspection Protocols were used during this inspection:

Dining Observation
Nutrition and Hydration
Snack Observation

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

- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC - Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO - Work and Activity Order	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 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #004 that sets out the planned care for the resident.

On an identified date and time, the inspector conducted a dining room observation on an identified care area as part of the follow-up to a compliance order from inspection #2019_583117_0051.

Resident #004 was seated by the dining room's table and napkins were placed at their sitting place with cutlery. PSW #102 assisted the resident with meals and then moved away leaving the napkins on the dining room table.

Review of resident #004's current written plan of care directed staff not to leave napkins at resident #004's sitting place in the dining room due to choking risk as the resident will put them in their mouth.

In an interview, PSW #102 indicated that resident #004 was putting anything left on the table in their mouth on admission and was at high risk of choking. The PSW stated that the resident's health condition has deteriorated, and they were not able to pick and eat anything without assistance.

In separate interviews, RN#103 and NS #105 indicated that nurses were expected to review and update each resident's plan of care quarterly. They acknowledged that the intervention mentioned above should have been removed from the resident's plan of care as the resident's condition has changed. Therefore, the plan of care did not set out the planned care for resident #004 as staff were leaving the napkins on the resident place on the dining room table. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001, #003, #005 and #006, as specified in the plan.

On November 29, 2019 Compliance Order (CO) #001 from inspection # 2019_583117_0051 was issued based on the licensee's non-compliance with LTCHA s. 6 (7).

The Licensee was ordered to be compliant with LTCHA, 2007, s.6 (7)
Specifically, the licensee should have
a) Ensured that the plan of care for resident #002, and any other residents on a

therapeutic pureed and diabetic diet, is provided to the residents as specified in their plans of care, during the provision of beverages and snacks.
b) Reviewed with all Personal Support Workers (PSW) the beverage and snack dietary menu, specifically in regard to therapeutic pureed and diabetic snack options, measure adherence to the beverage and snack dietary menu on a weekly basis on all units for a duration of three (3) consecutive weeks and take necessary corrective actions if PSWs do not adhere to the established menu.
c) A written record must be kept of everything required under (b).

In the current inspection (2020_818502_0002), it was determined that the licensee failed to comply with LTCHA, 2007, s.6 (7) of CO #001 as it applied to residents #001, #003, #005 and #006. As such, the licensee failed to comply with s. 6 (7) of the LTCHA by failing to ensure that the care set out in the plan of care was provided to those residents as specified in the plan.

On an identified date and time, the inspector observed PSW #101 assisting resident #003 with meal. Resident #003's beverage had specified thickened and the PSW used a tea spoon to assist the resident.

Review of resident #003's current written plan of care indicated a specified condition and required specified fluid consistency and served in an identified adapted eating aid to ensure compliance.

In separate interviews, PSWs #101 and #102 indicated that they were aware of resident #003's diet requirements, but they had downgrade the fluid consistency to another consistency. PSWs #101 and #102 indicated that the downgrade was consistency was routinely done by most PSWs as the fluid did not drip out of the resident mouth and makes the feeding easier. They also stated that downgrading the consistency was not putting the resident at risk because the fluid was thicker than what the resident needs. The PSWs stated that they had not communicated the change with the Registered Nursing staff or the Registered Dietitian.

In an interview, RPN #104 stated that PSW #101 did not consult them before feeding the resident different fluid consistency. The RPN indicated they were aware that PSWs were taking initiative without informing the nurses, to downgrade the resident's food texture and fluid consistency if they believed the resident could not handle the prescribed diet. The RPN indicated that one month prior to this inspection, PSW #101 served resident #008, specified food texture and fluid consistency instead of their prescribed diet. They reported the incident to

the Nursing Supervisor (NS) #108.

In an interview, NS #108 stated that PSWs were expected to serve the residents the prescribed diet and report any concern to the registered nursing staff, who will send a referral to the registered dietitian. NS #108 indicted that downgrading the resident's diet was not PSWs or Nurses role and they were not aware that PSWs were doing so. The NS acknowledged that PSW #101 did not provide resident #003 with the specified fluid consistency mentioned above as specified in the pan of care. [s. 6. (7)]

3. On an identified date and time, the inspector observed resident #005 having specified symptoms while drinking specified beverage consistency.

Review of resident #005's nutritional assessment indicated that the resident's diet was changed to specified texture and fluid consistency as the resident was having the symptoms identified above during meal. RD #106 documented that the specified fluid consistency was safer for the resident.

Review of resident #005's current written plan of care indicated a diagnosis that included CVA/stroke. The written plan of care indicated that resident #005 required fluid thickened to honey consistency and eat independently with supervision.

In an interview, PSWs #100 stated being aware that resident #005 required the fluid consistency identified above. PSW #100 acknowledged that the beverage served to resident #005 was not thickened the required consistency as they did not follow the guideline to thicken the identified beverage.

In an interview, NS #108 acknowledged that PSW #100 did not provide resident #005 with the beverage consistency mentioned above as specified in the pan of care. [s. 6. (7)]

4. On an identified date and time the inspector observed PSW #107 serving resident #006 beverage with specified consistency.

Review of resident #006's nutritional assessment, indicated that the resident's diet was downgraded as the staff observed the resident had specified condition on multiple occasions during identified care. RD #106 documented that the specified consistency was safer for the resident.

Review of resident #006's current written plan of care indicated specified health condition and required specified fluid consistency.

In an interview, PSWs #107 indicated that they were aware of resident #006 fluid consistency requirement. PSW #107 acknowledged that the beverage prepared for resident #006 did not have the specified consistency as they did not follow the recipe.

In an interview, NS #108 acknowledged that PSW #107 did not provide resident #006 with nectar thick coffee as specified in the pan of care. [s. 6. (7)]

5. On an identified date and time, the inspector observed RPN #109 assisting resident #001 with specified care.

Review of the physician's order indicated an ordered of specified fluids consistency.

Review of resident #001's nutritional assessment and current written plan of care indicated the resident had an identified diagnosis and a specified treatment. Following their hospitalization, the resident agreed to a specified food intake and fluid consistency at an identified meal service. The RD documented that the resident was at high risk of a specified condition.

In a combine interview, RPN #109 and RPN #114 stated that they were aware of resident #001 specified diet's order and intake mentioned above. They indicated that the were downgrading the fluid consistency because the resident did not tolerate the diet mentioned above. The RPNs were not able to identify what fluid consistency was to resident #001. The RPNs indicated that they did not send a referral to the registered dietitian when they had concern about the resident ongoing identified symptoms during the meal service or when they did not provide the identified fluid consistency to the resident as per plan.

In an interview, RD indicated that resident #001 had a Speech Language Pathologist (SLP)'s assessment prior to their admission in the home, and they were at high risk for specified condition mentioned above. The resident's diet on admission and their specified intake were specific with a goal to improve their quality of life. As result the resident will always the symptoms mentioned above during meal.

The RD stated that since the resident's admission in the home, they had been hospitalized on two occasions due to the specified condition mentioned above. The RD stated that they were not aware of the process the nurses were using to downgrade the resident diet. The RD stated that they did not complete a swallowing assessment, did not refer the resident to a SLP and did not discuss with the attending physician when they became aware that the nurses were not providing honey thick consistency to the resident as per care plan.

The resident was assessed by the Speech Language Pathologist prior to their admission in the home and required a specified fluid consistency. The nurses had concern providing that diet as the resident had specified symptom continuously. Without any direction from the RD, SLP or the attending physician if resident #001's prescribed diet order required modification, the nurses downgraded the resident's fluid consistency. Following an episode of an identified health condition, the RD became aware that the nurse were not offering the prescribed diet to the resident as specified in the plan of care. They did not take necessary steps including reassessment or referral to SLP to ensure adherence to the resident's diet order during meal and snack. Therefore, the licensee failed to provide care as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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

In accordance with O. Reg. 79/10, r. 30. (1), the licensee was required to 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.

Specifically, the licensee did not comply with the revised procedure put in place in January 2020, to prepare nectar and honey thick consistency tea and coffee.

Review of the licensee's procedure to prepare nectar and honey thick consistency tea and coffee directs staff to poor coffee until the top of the mug's handle was reached. Then add two scoops of thichenUp powder for nectar consistency and three for honey consistency. As needed if milk should be added, staff should use pre-packed milk of nectar or honey consistency.

On an identified date and time, the inspector conducted snack observation on identified floors as part of the follow-up from inspection # 2019_583117_0051.

During the first observation, resident #006 requested an identified beverage. PSW

#107 did not follow the procedure to prepare nectar and honey thick consistency mentioned above as the beverage served to the resident did not thicken to the desired consistency.

Review of the Medicare home page indicated a memo from the Food Services Supervisor. The memo informed staff that there was a new procedure to thicken tea and coffee that was added to the snack carts and kitchenette and directed staff to follow the new procedure for meals and snacks.

In separate interviews, PSW #107, PSW #111 and PSW #113 stated that they were not aware of the procedure, because they read Medicare when they start their documentation, not at the beginning of the shift.

In separate interviews, RPN #104, NS #108 stated that it was the PSWs responsibility to become aware of any change related to resident's care including memo posted on Medicare. They acknowledged that PSW #107 did not prepare the beverage as per procedure posted on the snack cart. Therefore, the licensee did not comply with the procedure to prepare thickened coffee at nectar and honey consistency. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the procedure was complied with, to be implemented voluntarily.

Issued on this 26th day of May, 2020 (A2)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIENNE NGONLOGA (502) - (A2)
Inspection No. / No de l'inspection :	2020_818502_0002 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022164-19 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	May 26, 2020(A2)
Licensee / Titulaire de permis :	United Counties of Prescott and Russell 59 Court Street, Box 304, L'Orignal, ON, K0B-1K0
LTC Home / Foyer de SLD :	Residence Prescott et Russell 1020 Cartier Boulevard, HAWKESBURY, ON, K6A-1W7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Alexandre Gorman

Ontario

Ministry of Long-Term Care

Ministère 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 United Counties of Prescott and Russell, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_583117_0051, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall comply with LTCHA, 2007, s.6 (7)

Specifically, the licensee shall ensure that:
a) The care planned for residents #001, #003, #005, #006, and any other residents on any modified diet including fluid consistency and food texture, is provided to the residents as specified in their plans of care during meals and snacks.

b) Ensure that the nursing staff and dietary staff collaborate in the implementation of the care planned for residents #001, #003, #005, #006, and any other residents, so that the adherence of the modified diet is consistent at meals and snacks.

c) Residents #001, #003, and any other residents, who is noted to have difficulty tolerating their prescribed diet, is referred to and reassessed by the Registered Dietitian or external resource including Speech Language Pathologist.

d) Adherence to the resident's prescribed diet during meal and snack services is measured on a weekly basis on all units, and necessary corrective actions are taken when direct care staff do not adhere to the prescribed diet, when assisting the resident during meal and snack.

e) A written record must be kept of everything required under (b, c, and d).

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001, #003, #005 and #006, as specified in the plan.

On November 29, 2019 Compliance Order (CO) #001 from inspection # 2019_583117_0051 was issued based on the licensee's non-compliance with LTCHA s. 6 (7).

The Licensee was ordered to be compliant with LTCHA, 2007, s.6 (7)
Specifically, the licensee should have
a) Ensured that the plan of care for resident #002, and any other residents on a therapeutic pureed and diabetic diet, is provided to the residents as specified in their

plans of care, during the provision of beverages and snacks.
b) Reviewed with all Personal Support Workers (PSW) the beverage and snack dietary menu, specifically in regard to therapeutic pureed and diabetic snack options, measure adherence to the beverage and snack dietary menu on a weekly basis on all units for a duration of three (3) consecutive weeks and take necessary corrective actions if PSWs do not adhere to the established menu.
c) A written record must be kept of everything required under (b).

In the current inspection (2020_818502_0002), it was determined that the licensee failed to comply with LTCHA, 2007, s.6 (7) of CO #001 as it applied to residents #001, #003, #005 and #006. As such, the licensee failed to comply with s. 6 (7) of the LTCHA by failing to ensure that the care set out in the plan of care was provided to those residents as specified in the plan.

On an identified date and time, the inspector observed PSW #101 assisting resident #003 with meal. Resident #003's beverage had specified thickened and the PSW used a tea spoon to assist the resident.

Review of resident #003's current written plan of care indicated a specified condition and required specified fluid consistency and served in an identified adapted eating aid to ensure compliance.

In separate interviews, PSWs #101 and #102 indicated that they were aware of resident #003's diet requirements, but they had downgraded the fluid consistency to another consistency. PSWs #101 and #102 indicated that the downgrade was consistency was routinely done by most PSWs as the fluid did not drip out of the resident mouth and makes the feeding easier. They also stated that downgrading the consistency was not putting the resident at risk because the fluid was thicker than what the resident needs. The PSWs stated that they had not communicated the change with the Registered Nursing staff or the Registered Dietitian.

In an interview, RPN #104 stated that PSW #101 did not consult them before feeding the resident different fluid consistency. The RPN indicated they were aware that PSWs were taking initiative without informing the nurses, to downgrade the resident's food texture and fluid consistency if they believed the resident could not handle the prescribed diet. The RPN indicated that one month prior to this inspection, PSW #101 served resident #008, specified food texture and fluid consistency instead of

their prescribed diet. They reported the incident to the Nursing Supervisor (NS) #108.

In an interview, NS #108 stated that PSWs were expected to serve the residents the prescribed diet and report any concern to the registered nursing staff, who will send a referral to the registered dietitian. NS #108 indicted that downgrading the resident's diet was not PSWs or Nurses role and they were not aware that PSWs were doing so. The NS acknowledged that PSW #101 did not provide resident #003 with the specified fluid consistency mentioned above as specified in the pan of care. (502)

2. On an identified date and time, the inspector observed resident #005 having specified symptoms while drinking specified beverage consistency.

Review of resident #005's nutritional assessment indicated that the resident's diet was changed to specified texture and fluid consistency as the resident was having the symptoms identified above during meal. RD #106 documented that the specified fluid consistency was safer for the resident.

Review of resident #005's current written plan of care indicated a diagnosis that included CVA/stroke. The written plan of care indicated that resident #005 required fluid thickened to honey consistency and eat independently with supervision.

In an interview, PSWs #100 stated being aware that resident #005 required the fluid consistency identified above. PSW #100 acknowledged that the beverage served to resident #005 was not thickened the required consistency as they did not follow the guideline to thicken the identified beverage.

In an interview, NS #108 acknowledged that PSW #100 did not provide resident #005 with the beverage consistency mentioned above as specified in the pan of care. (502)

3. On an identified date and time the inspector observed PSW #107 serving resident #006 beverage with specified consistency.

Review of resident #006's nutritional assessment, indicated that the resident's diet was downgraded as the staff observed the resident had specified condition on multiple occasions during identified care. RD #106 documented that the specified consistency was safer for the resident.

Review of resident #006's current written plan of care indicated specified health condition and required specified fluid consistency.

In an interview, PSWs #107 indicated that they were aware of resident #006 fluid consistency requirement. PSW #107 acknowledged that the beverage prepared for resident #006 did not have the specified consistency as they did not follow the recipe.

In an interview, NS #108 acknowledged that PSW #107 did not provide resident #006 with nectar thick coffee as specified in the pan of care. (502)

4. On an identified date and time, the inspector observed RPN #109 assisting resident #001 with specified care.

Review of the physician's order indicated an ordered of specified fluids consistency.

Review of resident #001's nutritional assessment and current written plan of care indicated the resident had an identified diagnosis and a specified treatment. Following their hospitalization, the resident agreed to a specified food intake and fluid consistency at an identified meal service. The RD documented that the resident was at high risk of a specified condition.

In a combine interview, RPN #109 and RPN #114 stated that they were aware of resident #001 specified diet's order and intake mentioned above. They indicated that the were downgrading the fluid consistency because the resident did not tolerate the diet mentioned above. The RPNs were not able to identify what fluid consistency was to resident #001. The RPNs indicated that they did not send a referral to the registered dietitian when they had concern about the resident ongoing identified symptoms during the meal service or when they did not provide the identified fluid consistency to the resident as per plan.

In an interview, RD indicated that resident #001 had a Speech Language Pathologist (SLP)'s assessment prior to their admission in the home, and they were at high risk for specified condition mentioned above. The resident's diet on admission and their specified intake were specific with a goal to improve their quality of life. As result the resident will always the symptoms mentioned above during meal.

The RD stated that since the resident's admission in the home, they had been hospitalized on two occasions due to the specified condition mentioned above. The RD stated that they were not aware of the process the nurses were using to downgrade the resident diet. The RD stated that they did not complete a swallowing assessment, did not refer the resident to a SLP and did not discuss with the attending physician when they became aware that the nurses were not providing honey thick consistency to the resident as per care plan.

The resident was assessed by the Speech Language Pathologist prior to their admission in the home and required a specified fluid consistency. The nurses had concern providing that diet as the resident had specified symptom continuously. Without any direction from the RD, SLP or the attending physician if resident #001's prescribed diet order required modification, the nurses downgraded the resident's fluid consistency. Following an episode of an identified health condition, the RD became aware that the nurse were not offering the prescribed diet to the resident as specified in the plan of care. They did not take necessary steps including reassessment or referral to SLP to ensure adherence to the resident's diet order during meal and snack. Therefore, the licensee failed to provide care as specified in the plan of care.

The severity of this issue was determined to be a level 2 as there was a Minimal Risk to the residents. The scope of the issue was a level 2 as four out of eight residents reviewed were affected. The home had a level 4 history as they had Re-issued CO to the same subsection of the LTCHA.

Due to the severity, scope, and history, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 24, 2020(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

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 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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health 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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 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 26th day of May, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JULIENNE NGONLOGA (502) - (A2)

Ontario

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Ministère des Soins de longue durée

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