Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 26, 2016	2016_325568_0016	015521-16 / 013964-16	Follow up

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST GUELPH ON N1H 8M8

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

DOROTHY GINTHER (568)

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): July 12, 13, 14, 15, 18, and 19, 2016

Inspector Amie Gibbs-Ward (630) was present for the inspection

Follow-up to log #008065-16 inspection # 2016_325568_0011:
CO # 001 regarding care not being provided as per the plan of care related to supplements
CO # 002 regarding bed rails - residents and their bed systems not being assessed
CO # 003 related to minimizing the risk of altercations between residents exhibiting

responsive behaviors
CO # 004 regarding residents that are dependent on staff and should be repositioned every two hours

Follow-up to log #000864-16 inspection # 2016_448155_0002:
CO #001 regarding policies not being complied with - Falls Preventions, Nutrition and Hydration, Weight and Height Monitoring, Head Injury Routine, Spa (Shower, Tub Bath, Sponge Bath), Personal Care Ware, Food Temperatures

Critical Incident 2915-000048-16 log #020964-16 related to alleged resident neglect was completed in conjunction with this inspection.

During the course of the inspection, the inspector(s) spoke with the Interim Assistant General Manager, new Assistant General Manager, Director of Nursing, Food Services Manager, Assistant Director of Nursing, three Dietary Aides,11 Registered Practical Nurses, three Registered Nurses, two Registered Dietitians, a Kinesiologist, one Neighbourhood Coordinator, Director of Hospitality and Food Services, Director of Environmental Services, 17 Personal Care Aides, one Personal Care Aide student, one RAI/QI lead, a Nursing Consultant, residents and their families.

The Inspector also also toured the home, observed meal service; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, investigation notes; observed the provision of resident care and resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

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

- **6 WN(s)**
- **1 VPC(s)**
- **5 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. 50.	WN	2016_325568_0011	568
O.Reg 79/10 s. 50. (2)	CO #004	2016_325568_0011	568
O.Reg 79/10 s. 54.	CO #003	2016_325568_0011	568

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident is offered a minimum of, three meals daily; a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening.

1) Observations on a specified date at 0845 hours found resident #023 was not in the dining room for the breakfast meal and was observed to be sleeping in bed. At 0930 the resident was observed to still be in bed sleeping. At 1010 hours the resident was observed receiving morning care from a Personal Care Aide (PCA) but no food or fluids were observed being offered by the PCA. Observations from 1010 to 1045 hours found resident #023 was not offered food or fluids from staff. At 1045 a PCA student who was delivering the snack cart offered resident #023 a drink, but did not offer food. Resident #023 refused to drink at that time and had no intake. Intake record for the specified date showed no food or fluid intake at breakfast and morning teacart.

On the specified date, a PCA reported that when resident #023 did not come for breakfast they would usually offer them food and a drink when they woke up or something from the morning snack cart. The staff member said they did not usually offer a tray at breakfast for residents who did not attend, as it was too close to the morning snack cart. The PCA reported that they only use the "tray offered" row of the flow sheets for residents that don't usually miss breakfast.

On the specified date, the RPN Team Lead told inspector #630 that if a resident did not go to the dining room for lunch or supper they would usually save food from the meal and offer it later. At breakfast this practice occurred less often. The RPN said that in the morning something would be offered from the snack cart or a piece of toast prepared for the resident.

During observations on the specified date, resident #023 was not up for breakfast and was not offered a snack or toast later in the morning when they got up.

During an interview with the Director of Nursing (DON) and Nurse Consultant, it was reported that staff were expected in the home to offer tray service to residents not in the dining room at a meal and that intake would be documented on the Nutrition and Hydration Flow Sheets. The Nurse Consultant reported the home had implemented a "tray offered" row on the personal care observation and monitoring form to help monitor the trays that had been offered.

Review of the clinical record for resident #023 on the specified date, found the following:
-Nutrition and Hydration Flow Sheet for a one month period showed 13 out of 13 (100 per cent) breakfast meals the resident had no intake and was documented as "sleep" and no food offered; 10 out of 13 (77 per cent) morning teacart was documented as "sleep" and no food offered; four out of 13 (31 per cent) afternoon teacart was documented as "sleep" and no food offered; one out of 13 (8 per cent) dinner meals was documented as "sleep" and no food offered; and 12 out of 13 (92 per cent) evening teacart documented as "sleep" and no food offered.
- Documentation on the Nutrition and Hydration Flow Sheet for three days in the specified month showed that the only meal or snack where food was consumed was the lunch meal.
- The personal Care Observation and Monitoring form for the first fourteen days of the month showed no tray service offered on any of these days.
- Plan of care for resident #023 identified them as being a "High Nutritional Risk". It did not identify sleeping through meals, or provide direction for staff if the resident slept through a meal or a snack. No specialized snacks for morning teacart were identified as part of the plan of care.

A Registered Dietitian told inspector #630 that it was the expectation of the home that for residents who slept through breakfast they would be offered a tray or a special higher calorie snack in order to help meet their nutrition and hydration needs.

The Director of Hospitality and Food Services and Food Services Manager (FSM) told inspector #630 and #568 that the resident's life plan should indicate whether the resident preferred to sleep through meals and snacks. It was also reported that residents who missed the regular breakfast service should be offered a meal later in the morning through tray service. The FSM reported that there was no tracking system in place that they were aware of in terms of when trays were requested or offered to residents.

2) Review of a Critical Incident (CI) report found that the Neighbourhood Coordinator (NC) had assessed the nutritional intake documentation of an identified resident at 1530 hours and it was documented that the resident was sleeping in the morning and not fed. Further, morning snack and lunch were left unrecorded. The resident was noted by the charge nurse as alert and awake throughout the day. The NC called the team lead and the PCA responsible and they confirmed no nutrition was offered.

During observations by inspector #568 on a specified date, it was noted that the

identified resident was not brought to the dining room for the evening meal until 1750 hours. Many of the residents had finished their meal and left the dining room.

A PCA told the inspector that the resident's nutritional intake had decreased over the past couple of weeks and their care needs had changed. They said that residents who slept through breakfast or who were not up for breakfast were usually offered trays. Their role in the dining room was to order and help prepare the trays, but usually it was another staff who delivered the trays. The PCA said they could not recall whether a tray was prepared and offered to the identified resident during the two specified days.

A second PCA told the inspectors that the identified resident had been missing for breakfast. A Registered Practical Nurse (RPN) reported to the inspector that the days before the identified resident's health status changed they were having more difficulties attending meals. The RPN reported an awareness that the resident was not going down for meals. The RPN believed that the resident was being offered a tray by the PCAs when they didn't attend meals.. The RPN acknowledged that they did not double check whether the resident was being fed and did not usually check the Food and Nutrition Flow Sheets at the end of the shifts.

Review of the clinical record for the identified resident on a specified date, found the following:
-Nutrition and Hydration Flow Sheet for the month, showed seven out of 13 (54 per cent) breakfast meals the resident had no intake and was documented as "sleep" and no food offered; 13 out of 13 (100 per cent) morning teacart was documented no food offered; seven out of 13 (54 per cent) lunch meals the resident had no intake and was documented as refused; 13 out of 13 (100 per cent) afternoon teacart was documented as no food offered; and 12 out of 13 (92 per cent) evening teacart documented as no food offered.
- Nutrition and Hydration Flow Sheet showed that on two days during that month the resident had no food intake. On another day the only meal or snack where food was consumed was the dinner meal and the resident was coded as having consumed "1/4" of the protein item. Documentation on another day indicated that the only meal or snack where food was consumed was the afternoon cart and the resident was coded as having consumed "1/4" of the snack item.
- The personal care observation and monitoring form for a one week period during the month showed no tray service offered on any of these days.
- Plan of care identified the resident as having "Moderate Nutritional Risk" due to potential for inadequate nutritional intake but did not identify sleeping through meals or

direction for staff if the resident slept through a meal or a snack. No specialized snacks for morning teacart were identified as part of the plan of care.

3) Review of resident #001's plan of care related to nutrition and hydration identified that the resident was a high nutritional risk related to poor intake of food plus refusals. The resident was reported to enjoy a specified item at breakfast and if meals were refused the resident was to be provided with an alternate.

Record review identified that resident #001 had no intake at breakfast on nine out of the first twelve days in the identified month. On three of those days it was documented that the resident was sleeping. On two of the twelve days the resident refused. During the morning tea cart for the same twelve days there was no documentation that the resident had anything to eat and on four of the twelve days they had no fluids in the morning.

On a specified date, resident #001 was observed in their room sleeping at 0830 and 0845 hours. At 0930 hours the resident was sitting dressed in their room. There was no sign of a tray in the resident's room.

During an interview with a PCA they reported that the resident's food and fluid intake was documented on the Nutrition and Hydration Flow Sheet following each meal and snack cart. If a resident refused then this was also documented. The PCA that documents for a particular meal or snack flags those residents that do not come to the dining room so that a tray can be offered afterward. When the flow sheet documentation is blank for a meal or has a "nothing" sign then that would mean the resident did not eat that meal. A PCA stated that Resident #001 often slept through breakfast but would have a snack when they got up. When shown the Nutrition and Hydration Flow Sheet for resident #001 the staff member acknowledged that there was no documentation that the resident was offered breakfast or a morning snack/beverage on a number of days in the specified month including the observation day. (#568)

The licensee has failed to ensure that each resident was offered a minimum of, three meals daily; a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening.

The scope of this issue was a pattern and the severity of harm a level two with a potential for risk or harm to residents. The home had a history of non-compliance with this subsection of the regulation. It was issued as a Voluntary Plan of Correction on January 19, 2016 during the Resident Quality Inspection and issued again as a Voluntary Plan of

Correction on March 17, 2016. [s. 71. (3)]

Additional Required Actions:

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

WN #2: 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 has failed to ensure that where bed rails are used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

This was a follow-up to an order issued April 18, 2016, under log #008065-16 inspection #2016_325568_0011 with a compliance order date of May 20, 2016. The order included that where bed rails were used; the resident was to be assessed and his or her bed system evaluated in accordance with evidence based practices to minimize risk to the resident, including when there was a change to the resident's bed system. The home was to ensure that there was an organized method to track changes to resident's bed systems.

During observations on two consecutive days of the inspection, it was noted that resident #010 had a bed rail up on their bed.

The Director of Environmental Services (DES) shared that the home had instituted a new process for the assessment of bed systems and this process was now coordinated by the environmental services department. All beds in the home were assessed annually by an external contractor. Most recently they were assessed in April 2016. Any beds that did not pass any of the potential zones of entrapment were highlighted and the home addressed the individual concerns. Once changes were made to the beds they were retested to ensure that they passed. Any time a change is made to the bed system including the addition of bed rails or change in mattress type a maintenance requisition would be sent using their electronic system. The maintenance staff receive these requisitions and followup. When they reassess a bed the maintenance staff complete a Schlegel Villages Bed Entrapment audit form which records the room number, specific features of the bed system, use of bed rails and the results of the entrapment testing for zones 1-7. The audit is signed and dated by maintenance staff. If any zone fails testing then the DES and the DON are notified and actions taken to correct the failed zones are also documented. These forms are kept in the Bed Entrapment binder.

During an interview with a Registered Practical Nurse they reported that resident #010 had a bed rail up on their bed. The resident used the bed rail to assist with their activities of daily living. The RPN indicated that family had requested that the resident have the bed rail, and that in these cases family sign a consent for the bed rail. The RPN was unable to locate a consent for the bed rail.

Review of resident #010's plan of care indicated that the resident used one bed rail when in bed. The most recent Bed Rail Assessment identified that resident #010 used a bed rail for assistance with their activities of daily living.

The current Bed Assessment Evaluation spreadsheet identified that the bed in resident #010's room had no bed rails. There were no Schlegel Villages - Bed Entrapment Audit forms found in the Bed Entrapment Binder for the bed system used by resident #010.

During an interview with the Director of Nursing they said they had followed up with the Director of Environmental Services regarding resident #010's bed and they said there were no maintenance requests related to the bed system in that room. The most up to date information related to resident #010's bed would be the spreadsheet completed by the external consultant in April 2016. The DON acknowledged that resident #010's bed system had not been assessed with the bed rail.

The scope of this issue was isolated and the severity of harm a level two with a potential

for harm to the resident. The home had a history of non-compliance with this subsection of the regulation. A compliance order was issued on March 17, 2016 with a compliance date of May 20, 2016. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This was a follow-up to an order issued March 17, 2016, under log #000864-16 inspection #2016448155_0002 with a compliance order date of May 16, 2016. The order included that the home would prepare, submit and implement a plan to ensure that plans, policies, protocols, procedures, strategies or systems instituted or otherwise put in place related to Fall Prevention and Management, Nutrition and Hydration, Weight and Height Monitoring, Head Injury Routine, Spa, Personal Care Ware, Food Temperature Control, and Catheter were complied with.

The home's policy titled "Nutrition and Hydration", Tab 04-46 dated April 2014, indicated that each evening the Nutrition and Hydration Flow Sheets would be tallied by the night Personal Care Aide (PCA) team, which would include the Daily Additional Fluids Chart. The night Registered Practical Nurse/Registered Nurse would review and initial the total

daily fluid intake. Any resident who had a fluid intake less than their estimated fluid requirement would be reported to the oncoming RPN/RN so that interventions could be initiated. Commercial supplements would be documented on the MAR and the Daily Additional Fluids Charts. Interventions would include additional fluids being encouraged at each meal and via the Teacarts. Extra fluids consumed by the resident would be documented by the RPN/RN at medication pass on the Daily Additional Fluids chart. The RPN would assess signs and symptoms of dehydration using the Dehydration Risk Assessment Tool. The Request for Nutritional Consultation would be completed when a resident had a fluid intake of less than 1000 mls or per individual fluid requirement as per the Plan of Care for three (3) consecutive days and there was at least one sign or symptom of dehydration present. The policy also indicated that the Nutrition and Hydration Binder would be placed on the Teacart at the time of each nourishment service. Food and fluid intake would be documented at the time of service.

a) A review of the July 2016 Nutrition and Hydration Flow Sheet for resident #023 showed there were no RPN/RN initials for 11 out of 11 days (100 per cent). This review also showed that fluid intake from the additional fluids chart was not completed on the flow sheet for nine out of eleven days (82 per cent). A review of the July 2016 Daily Additional Fluids Charts found resident #023 was not included on the list for 11 out of 12 days (92 per cent). Resident #023 was included on the list on one of the days, but this record was incomplete as it only included fluids taken at 0800 hours and 1200 hours and did not include the total.

Observations at the lunch meal on a specified date in July found that resident #023 consumed some of the nutritional supplement that was provided by the RPN but then refused to drink more. Review of the additional fluids on the Nutrition and Hydration Flow Sheet for the specified date showed the intake of this supplement was not identified on the record.

During an interview with a RPN it was reported that resident #023 had fluctuating fluid intake but usually did consume the supplement when offered. Resident #023 did not accept the full amount prescribed at lunch on the specified date. The RPN said that the Daily Additional Fluid Chart was only used for residents who had an intake less than their required amount. Review of the July 2016 Daily Additional Fluid Charts with the RPN identified that resident #023 was only included on this chart on one day in July and the documentation was incomplete.

During an interview with a Registered Dietitian (RD) they reported that nutritional

supplements were to be included in the additional fluids section of the Nutrition and Hydration Flow Sheets. Review of the records for resident #023 with the RD indicated that the additional fluids were not completed as per the home's policy.

During an interview with the Nurse Consultant they indicated that the direction given to staff during the education sessions was different than the process specified in the home's policy. The Nurse Consultant said that the "Daily Additional Fluids" did not include supplements unless a resident was at high risk for poor fluid intake and that the registered staff were directed to only initial the sheets if they had been notified of a poor fluid intake.

During an interview with the Food Services Manager they said that it was the home's expectation that registered staff would review and sign the Nutrition and Hydration Flow Sheet on a daily basis. (#630)

b) Review of the plan of care for resident #003 for Dehydration/Fluid Maintenance identified the resident as being a concern related to insufficient fluid intake. Interventions to address this concern included offering the resident fluids they enjoy; assessing skin turgor for dryness and slow reaction time; ensuring that when the resident did not meet their daily fluid requirements for 3 days in a row that a dehydration risk assessment was completed to monitor for signs/symptoms of dehydration.

Record review revealed the Dehydration Report for a specified month and neighbourhood. The report identified resident #003's estimated daily fluid requirement. Documentation of the daily fluid intake for resident #003 was below the estimated requirement on four consecutive days in the specified month. The resident was listed on the Daily Additional Fluids Chart for two of the four days. Records did not reveal a Dehydration Risk Assessment for resident #003 and there was no documentation of a request for nutritional consultation.

During an interview with a Registered Dietitian they indicated that when a resident has a fluid intake below their minimum level for three consecutive days then nursing staff complete a Dehydration Risk Assessment. If there are any signs or symptoms of dehydration then they are to make a referral to the RD. The RD was shown the Dehydration Report for the specified neighbourhood and they agreed that resident #003's intake was below their minimum requirement for four consecutive days. The RD said that at a minimum the resident should have had an assessment. They had no record that resident #003 had been referred for a nutrition/hydration consult.

The Assistant Director of Nursing (ADON) acknowledged that resident #003 had a fluid intake below their minimum requirement for four consecutive days in the specified month. After reviewing the clinical record for resident #003, the ADON stated that there was no Dehydration Risk Assessment completed and no referral to the Registered Dietitian as outlined in the home's policy. In addition, the ADON acknowledged that registered staff had not documented that they had reviewed the total daily fluid intake of residents by initialing on the Nutrition Hydration Flow Sheets. (568)

c) Observations on a specified date on one of the neighbourhoods from 1510 hours to 1530 hours found two PCAs serving food and fluids from the nourishment cart to residents in the lounge and then the cart was put away. The Nutrition and Hydration Binder was observed in the dining room not on the Teacart. PCAs were not observed recording the intake of residents at the time of service. The additional fluids section of the Nutrition and Hydration Flow Sheets was found to be incomplete for all residents at the time of observations.

The Food Services Manager (FSM) acknowledged that the Nutrition and Hydration Flow Sheets were not completed at the time of service as per the home's policy.

Observations on a specified date found a PCA student serving food and fluids to residents on one of the home neighbourhoods. No staff of the home were observed to be with the student during this time. The Nutrition and Hydration Binder was observed on the nursing station not on the Teacart. The PCA student was not observed to record the intake of residents at time of service. (#630)

The licensee failed to ensure that the Nutrition and Hydration policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy titled "Weight and Height Monitoring" Tab 04-76 dated August 2015, indicated that when a monthly weight identified a weight loss or gain of two kilograms (kg) from the previous month a reweigh would be completed and all weights would be documented electronically in the Village Software. It also indicated that when a monthly weight identified a weight loss or gain of two kilograms (kg) from the previous month, a reweigh would be completed and when unplanned weight change was identified the Team Leader would be notified and a complete a Request for Nutrition Consultation.

Review of the weights recorded in the village software for a specified Neighbourhood

found that for a ten week period, six out of thirty-two residents (19 per cent) in this area had a weight loss or gain of two kilograms from the previous month and no reweigh was documented electronically in the village software. Review of the clinical record for resident #024 identified a two point seven kilogram (five point one per cent) weight loss over one month. There was no documentation of a reweigh for resident #024 and no referral to the Registered Dietitian.

Review of the weights recorded in the village software for a second Neighbourhood found that for the same ten week period, 10 out of 32 residents (31 per cent) in this area had a weight loss or gain of two kilograms from the previous month and no reweigh was documented electronically in the village software.

Review of the weights recorded in the village Software for a third Neighbourhood found that for the ten week period, six out of 32 residents (19 per cent) in this area had a weight loss or gain of two kilograms from the previous month and no reweigh was documented electronically in the village software.

During an interview with a PCA they reported that there was a weight sheet that they wrote the weights on once a month, as well as if there was a reweigh needed. The PCA reported they do reweighs if a resident's weight was different from the previous month by two kilograms or if the nurse told them to reweigh a resident.

During an interview with a RPN it was reported that there was a weight sheet that the PCAs used to record the weights on, prior to the registered staff entering it into the village software. The RPN said a reweigh was done if a resident was up or down two kilograms or if requested by nursing or the RD based on the previous weight. The RPN said the reweighs should be added into village software, in addition to the original weight.

During an interview with a RD they said that the weights were taken each month for residents at the beginning of the month and then entered into the village software. The RD reported that they rely on the electronic weight record for the weights when doing assessments. They said they had been receiving referrals for weight loss but were still identifying residents who had weight loss of more than two kilograms in a month with no referral received.

The home failed to ensure that the Weight and Height Monitoring policy was complied with. (#630) [s. 8. (1) (a),s. 8. (1) (b)]

3. The home's policy titled "Spa (Shower, tub Bath, Sponge Bath) dated February 2016 indicated that staff are to document the type of spa provided and the level of assistance provided on the PSW Flow Sheet, including nail and skin care. When a Resident declines their spa after multiple attempts and negotiation, it must be documented on the PSW Flow Sheet under 'Bathing' as well as in the 'Behavior' section or in the Electronic Health Record if the village is paper free. The PCA will report this refusal to the Team Leader and the Team leader will document the reason for refusal and alternative interventions tried without success. If a resident refuses today, offer their spa the following day, or later in the shift.

a) The care plan for resident #023 with respect to bathing identified that the resident required extensive assistance for bathing. The Personal Care Observation and Monitoring Forms for a three week period identified that resident #023 was bathed four times. During two of the three weeks the resident received just one shower/bath and there was no documentation to indicate that the resident had either refused their shower/bath or was not available on the other days. Progress notes for the same period did not identify that the resident had refused their bath/shower, and if they had, what alternative interventions were tried.

During an interview with a Personal Care Aide (PCA) they indicated that resident #023 usually had a shower/bath twice a week. It was rare that the resident refused but on occasion due to staffing they may not have been able to complete the resident's shower/bath. In this situation the bath/shower would be moved to the next day. When a resident refused staff should document on their flow sheet and notify the registered staff. When shown the Personal Care Observation and Monitoring forms for resident #023 during the three week period the PCA acknowledged that there was no documentation to indicate that the resident had a shower/bath twice a week during this time. The PCA indicated that it was possible the resident had their shower/bath but it was not documented.

During an interview with a Registered Practical Nurse they reported that residents were given either a bath or shower twice each week unless otherwise indicated on their plan of care. If a resident refused their bath/shower, staff were to document on the flow sheet and let the registered staff know. The RPN acknowledged that there was no documentation on the PCA flow sheets to indicate that resident #023 was given a bath/shower twice a week during the three week period, and there was no documentation of refusal or the resident not being available.

b) The care plan for resident #001 with respect to bathing identified that the resident required extensive assistance for bathing. The resident would usually have a shower/bath and have their hair washed at this time. The Personal Care Observation and Monitoring Forms for a three week period identified that resident #001was given three showers/baths. During one of the three weeks documentation indicated that the resident did not have a bath or shower. There was no documentation to indicate that the resident had either refused their shower/bath or was not available. There was no documentation in the progress notes for the same period to indicate that the resident had refused their bath/shower, and if they had, what alternative interventions were tried.

During an interview with a Personal Care Aide (PCA) they indicated that resident #001 had a shower/bath twice a week. If the resident refused their shower/bath or the staff were unable to conduct it for some reason this would be documented on the Personal Care Observation Flow sheets that PCA staff complete every day. They would also alert the charge nurse who would inform the family if there were ongoing issues. When shown the Personal Care Observation and Monitoring forms for resident #001 during the three week period the PCA acknowledged that there was no documentation to indicate that the resident had a shower/bath twice a week. The PCA indicated that they were fairly sure the resident had a shower/bath more often but it may not have been documented.

During an interview with a Registered Practical Nurse they reported that residents were given either a bath or shower twice each week unless otherwise indicated on their plan of care. If a resident refused their bath/shower, staff were to document on the flow sheet and let the registered staff know. The RPN acknowledged that there was no documentation on the PCA flow sheets to indicate that resident #001 was given a bath/shower twice a week during the three week period and there was no documentation of refusal or the resident not being available.

The licensee failed to ensure that the Spa policy was complied with. [s. 8. (1) (a)]

4. The home's policy titled "Pain Management Program" dated November 6, 2015, identified under the procedure for registered staff that they would complete and document a pain assessment on initiation of a pain medication or PRN analgesic, when there are personal expressions exhibited by the resident that may be an indicator of the onset of pain and when there is a change in condition with pain onset.

Review of the progress notes for resident #028 identified that on a specified date at

approximately 1000 hours a Personal Care Aide reported that the resident had an area of altered skin integrity. The resident presented with some discomfort on movement of the area. Analgaesics were given by mouth for pain. A skin concern form was completed and noted in the TAR to monitor. Two days later a PCA mentioned that the resident was exhibiting signs of pain with movement. PRN analgaesics were given as per the medical directives. Four days later the resident complained of pain in the same area when touched and there were further signs of altered skin integrity. The resident refused to take medication by mouth and the analgaesics were given in a different form. Seven days after the initial reports of pain, the registered staff was alerted to the resident complaining of pain. The resident refused medication for pain and the resident was transferred to hospital for further evaluation.

During an interview with two PCAs they shared that resident #028 had been exhibiting signs and symptoms of pain since two areas of altered skin integrity were identified two weeks previous. The resident also demonstrated a change in care needs during this period of time. The PCAs stated that they had reported these changes to the registered staff on duty.

Clinical record review identified an Abbey Pain Scale completed six days after the initial pain was reported. There were no pain assessments completed for resident #028 when they first reported pain and when they were first given PRN analgesics.

During an interview with a RPN they indicated that when a resident reports a new pain they would usually assess using the Abbey pain Scale or the Face Pain Scale. The RPN acknowledged that they had not completed a pain assessment for resident #028 when the pain was first reported.

The licensee failed to comply with their Pain Management policy.

The scope this issue was a pattern and the severity of harm a level two - potential for actual harm. The compliance history was a level four - despite Ministry of health action (VPC, Order) non-compliance continues with original area of noncompliance. The compliance history identified that a Voluntary Plan of Correction was issued previously during the following inspections: October 17, 2013 related to the Nutrition and Hydration, bathing and restorative dining policies; November 7, 2013 related to the Falls Prevention and Management policy; April 14, 2014 related to the Weight Monitoring policy; April 22, 2014 related to the Catheter policy; May 21, 2014 related to the Nutrition and Hydration policy; June 4, 2014 related to the hiring policy; August 1, 2014 related to the Medication

Administration policy; October 15, 2014 related to the Nutrition and Hydration and Lost Items policies; November 20, 2014 related to the Skin and Wound policy; December 14, 2014 related to the Skin and Wound policy; April 14, 2015 related to the Weight and height Monitoring, Admission of Residents and Fall Prevention/Management policies; December 16, 2015 related to the Prevention of Abuse policy. During a Resident Quality Inspection on May 11, 2015 a compliance order related to Weight and Height Monitoring and Personal Assistance Safety Device policies was issued. This order was complied on September 13, 2015. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (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 the care set out in the plan of care was provided to the resident as specified in the plan.

This was a follow-up to an order issued April 18, 2016, under log #008065-16 inspection #2016_325568_0011 with a compliance order date of May 20, 2016. The order included that where a resident was identified in the plan of care as requiring a supplement, the supplement was provided to the the resident as set out in the plan of care, and the residents intake of the supplement was documented.

Review of resident #001's plan of care identified the resident as a high nutritional risk. Orders documented by the Registered Dietitian and outlined in the care plan related to nutrition/hydration indicated that resident #001 was to be provided with a nutritional supplement at each medpass and at an identified snack.

The medication administration record (MAR) identified that the nutritional supplement

was to be given three times daily at medpass and another supplement at the identified snack. For the first eleven days of the specified month documentation indicated that the nutritional supplement had been given three times on nine of the eleven days. On two of the days there was no documentation at the noon med pass that the resident received their supplement. In terms of the supplement that was to be given at snack, it was documented that the resident refused on eleven of the eleven days.

During an interview with a RPN they reported that it was the registered staff's responsibility to ensure the residents had their supplements if they appear on the medication administration record. When asked what the direction was for resident #001 in terms of their snack supplement, the RPN stated that it was to be given at the time of snack cart. The RPN acknowledged that the documentation in the MAR indicated that the resident had refused their snack supplement for the first eleven days of the specified month.

The Registered Dietitian shared that supplements are listed on the MAR with the exception of one specific kind. Registered Staff are expected to sign off on the supplement when it is given. In terms of resident #001, the RD was asked to clarify the order for the snack supplement. The RD stated that this order indicated that the resident was to be given the supplement at the time of the identified snack service. When shown that the resident had refused the supplement for the first eleven days of the specified month, the RD stated that the registered staff should have sent a referral to them indicating that the supplements were not being given. The Assistant Director of Care and RN acknowledged that the nutritional supplement had not been given to resident #001 as indicated in the plan of care. Registered staff should have notified the Registered Dietitian of the repeated refusals given that the resident was a high nutritional risk. [s. 6. (7)]

2. Review of the plan of care for resident #009 indicated that no bed rails were required at the present time and therefore the resident was considered a low risk for bed rail entrapment/injury. The bed rail assessment indicated that the resident had no bed rails and was low risk.

During observations on two consecutive days during the inspection, it was noted that resident #009's bed had a bed rail up.

During an interview with a Personal Care Aide they shared that resident #009 had a bed rail up for safety. When asked how staff were informed as to what type of bed rails, if

any, a resident would have, the staff member stated that this would be outlined in the resident's plan of care, which staff can access in their binders.

The RAI/QI staff stated that resident #009 should not have any bed rails raised on their bed as per their bed rail assessment and care plan. The staff member was shown resident #009's bed with the bed rail up. The RAI/QI staff was unsure why the bed rail was up and acknowledged that care was not being provided as set out in the plan.

The scope of this issue was isolated and the severity of harm a level two - potential for harm to residents. The home had a history of non-compliance with this subsection of the regulation. A compliance order was issued on April 14, 2014, with a compliance date of May 2, 2014. The order was complied on July 24, 2014. A Voluntary Plan of Correction was issued during inspections on October 15, 2014 and May 11, 2014. [s. 6. (7)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from neglect by staff in the home.

O.Reg 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident report described an incident where a resident was not fed on a

specified morning because they were sleeping; and there was no documentation to indicate the resident was given a morning snack or lunch on the same day. The Charge Nurse and Personal Care Aide assigned to the resident confirmed that no nutrition had been offered to the resident at breakfast, morning snack and lunch on the specified day. The CI was updated to indicate that resident #028 had declined medication and nourishment through the night and the following day, at which point they were transferred to hospital.

Review of the resident's plan of care identified that they were a moderate nutritional risk due to the potential for inadequate nutritional intake. The plan of care did not identify that the resident frequently slept through meals / snacks. The resident was identified as requiring assistance from staff for transfers.

Review of the progress notes for a two week period prior to the resident's transfer to hospital identified that PCAs had reported areas of altered skin integrity, verbal and physical expressions of pain, as well as changes in the identified resident's care needs to the RPN in charge. During interviews with several Personal Care Aides they reported that they had observed a decline in the identified resident's nutritional intake as well as a change in their care needs over the ten to fourteen day period prior to their transfer to hospital. The same staff stated that they had reported these changes as well as the resident's expressions of pain and changes in the altered skin integrity to registered staff, as well as management of the home. There was no documentation during the initial week following the identification of pain and altered skin integrity that the resident was assessed or that a referral was made for further evaluation of the concerns.

The Nutrition and Hydration Flow Sheet for the specified month, showed seven out of 13 (54 per cent) breakfast meals where the resident had no intake and was documented as "sleep" and no food offered; 13 out of 13 (100 per cent) morning teacarts where it was documented that no food was offered; seven out of thirteen (54 per cent) lunch meals the resident had no intake and was documented as refused; 13 out of 13 (100 per cent) afternoon teacarts where it was documented that no food was offered; and 12 out of 13 (92 per cent) evening teacarts where it was documented that no food was offered.
- Nutrition and Hydration Flow Sheet showed on two days during the month that the resident had no food intake. On one of the days, the only meal or snack where food was consumed was dinner and the resident was coded as having consumed "1/4" of the protein item. On another day, the only meal or snack where food was consumed was the pm cart and the resident was coded as having consumed "1/4" of the snack item.

A Skin Assessment Concerns form was completed on the specified date by the RPN. The form identified the resident as having two areas of altered skin integrity. It was also noted that the protocol was written in the TAR and that electronic documentation had been completed. The Skin Assessment Concerns form was signed off by the RAI/QI five days later. The Personal Care Observation and Monitoring Form indicated that there were no skin concerns identified during spa days by the PCA staff even after the altered skin integrity had been reported to registered staff.

During an interview with the RPN they shared that they were first alerted about a concern with the identified resident, seven days before they went to hospital. A Personal Care Aide brought to their attention that the resident had two areas of altered skin integrity. The staff member also told them that the resident was complaining of pain. When they assessed the resident they noted areas of altered skin integrity. The RPN stated that they could tell the resident was in discomfort from their expression. The RPN told this inspector that they notified the charge nurse (CN) who advised that they would come to assess. Because it was the end of the shift the RPN was unsure if the CN came. The RPN stated that the resident was given medication for pain and a Skin Concern form was completed. The areas of altered skin integrity were added to the TAR. The RPN could not recall the resident exhibiting signs of pain after the day the concern was first brought to their attention. When asked if other staff had reported the altered skin integrity, pain, or other changes related to the resident, the RPN stated that nothing was mentioned until six days later when it was reported that the resident had extreme pain. Upon further questioning, the RPN stated that someone might have mentioned the altered skin integrity when the resident was bathed at which time they checked on the resident and things were healing normally. The RPN stated that it was their practice to visualize the area of altered skin integrity each day before signing the TAR. Because there were no changes other than normal healing they did not document in the progress notes or alert other staff. The RPN reported that it was not until six days after they first assessed the resident that staff reported a change in the resident's care needs. The RPN acknowledged that they had noted that the resident had not been getting up for meals as much but they assumed they were getting a tray. When asked if the RPN reviewed the Nutrition and Hydration flow sheets to look at residents intakes the RPN said that sometimes they do but not always. The RPN did not recall looking at the identified resident's Nutrition Hydration flow sheet. In terms of the resident's pain, the RPN stated that usually the resident's pain would be assessed when the area of altered skin integrity was assessed. The RPN stated that they would do the Abbey Pain Scale after giving pain medication and document the response. The RPN acknowledged that they should have done a pain assessment when the resident first complained of pain.

During a second interview with the RPN they acknowledged that the ADOC had approached them regarding the identified resident and asked that they reassess the resident. The RPN did not recall being advised to contact the charge nurse. The RPN stated that they visualized the area of altered skin integrity and felt that it was resolving normally. At the time the resident was not complaining of pain and did not appear in any discomfort. When asked if the RPN conducted a physical assessment of the resident, the RPN could not recall.

The Neighbourhood Coordinator (NC) shared that they attend team meetings at shift change and and review progress notes in order to keep up to date on any resident changes. They said they were not aware of any concerns related to the identified resident until six days after the areas of altered skin integrity and pain were first documented. On that date, a PCA asked her to come to look at the resident. The NC stated that Assistant Director of Care was nearby and she asked her to come with her. Because of the resident's position and clothing it was difficult for the NC to visualize the area of altered skin integrity. The NC stated that the resident was upset and appeared in pain. The ADOC directed staff to put the resident back to bed and make them comfortable. Later that day the NC stated that she assisted a PCA with the resident's care. At that time they observed the altered skin integrity and noted that the resident was in pain while care was being provided. When asked if the NC had followed up with anyone regarding the observed altered skin integrity and pain observed, the NC stated that they didn't do anything until the following morning, at which point they called the Director of Nursing and asked them to assess the resident.

During an interview with the Assistant Director of Nursing (ADON) they stated that six days after the resident's pain and altered skin integrity were first documented, they were asked by the NC to look at the resident in light of concerns brought forward by a PCA. The ADON was not able to visualize the area of concern because of the resident's position and clothing, but it was obvious the resident was in pain. The ADON stated that they spoke with the RPN and asked them to assess for pain and to call the charge nurse. They also advised staff to put the resident back to bed. The ADON indicated that they did not circle back regarding this concern because they felt that clear direction had been given. The ADON reported to the inspector that there had been a notation about altered skin integrity approximately five days earlier on the nursing report, but it did not describe the area and nothing more was reported on subsequent days to indicate there was a concern.

During a telephone interview with a RN they confirmed that on a specified date they recalled being contacted by a RPN regarding the identified resident. The RN reports having gone to see the resident who was asleep. The RN stated that they did not visualize the areas of altered skin integrity nor did they complete a physical assessment. The RN stated that they did not want to disturb the resident. The RN shared that they included the areas of altered skin integrity on the daily report.

A RPN was asked if any staff had brought to their attention specific concerns over the last month regarding the identified resident. The RPN said that about two weeks ago two Personal Care Aides came to her and said that the resident was complaining of pain and exhibiting facial grimacing during cares. The RPN recalls going to see the resident and observing one area of altered skin integrity. The staff member said that attempts to move the resident were met with reports of pain and grimacing. The RPN said that they gave the resident medication as per their PRN orders, wrote a note on their electronic system, and notified the oncoming nurse at shift report. When asked if the RPN had assessed the areas of altered skin integrity during any of their shifts in the last couple of weeks, the staff member stated that they were not aware that there was more than one area. When shown the MAR for two dates when the RPN worked they acknowledged that it was their signature on one of the days, indicating that they had monitored the areas of altered skin integrity. The RPN stated that they did not recall seeing this notation and only looked at the one area.

During an interview with a Registered Nurse they shared that on a specified date, six days after altered skin integrity and pain were first documented for the identified resident, while making rounds to the different home areas they were told by staff on one of the neighbourhoods that a resident had an area of altered skin integrity that was resolving. Staff reported that they were unsure how this condition had occurred. The following day the RPN called to report that the area of altered skin integrity had spread. The RN assessed the resident and based on their findings advised the RPN to contact the physician. The RN stated that there were areas of altered skin integrity and the resident was reporting pain during physical assessment. Staff reported to the RN that the resident had been requiring increasing assistance with their cares since the altered skin integrity had first been identified one week previous.

During an interview with the Director of Nursing they acknowledged that there was a problem with the documentation of skin assessments for the identified resident by the Personal Care Aides. The DON stated that it didn't make sense that the Personal Care Observation Monitoring form completed after documentation that the resident had

altered skin integrity, indicated that the resident had no skin concerns. In terms of evaluating the areas of altered skin integrity, the DON stated that it was the home's expectation that if the area of altered skin integrity changed in an unpredictable way then the staff member would notify the charge nurse. The DON acknowledged that if different people were evaluating the altered skin integrity it would be difficult to know if it had changed, if there was no documentation. The DON stated that it would seem that the resident's altered skin integrity had changed since it was first reported, but these changes were not captured by staff monitoring the resident's skin. The DON acknowledged that there were gaps in the communication, assessment, and documentation of concerns including pain, altered skin integrity, nutrition and activities of daily living for the identified resident. The DON agreed that staff at multiple levels had failed to follow-up on concerns that had been identified.

The licensee failed to protect the resident from neglect.

The scope of this issue was isolated and the severity of harm a level three with actual harm to the resident. The compliance history was a level three with one or more related non-compliance in the last three years. The home had a history of non-compliance with this subsection of the regulation. A Voluntary Plan of Correction was issued during an inspection on February 19, 2014. [s. 19. (1)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the nutrition care and hydration programs included the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services.

Clinical record reviews and observations during the course of the inspection identified multiple residents who were sleeping through or refusing meals on a regular basis.
- Resident #023 was observed not to be in the dining room for the breakfast meal on two consecutive days while inspectors were in the home.
- The Nutrition and Hydration Flow Sheet for a thirteen day period in a specified month indicated that resident #028 had refused or slept through 19 out of 39 (49 per cent) meals. No request for nutrition consultation was found in the documentation regarding poor intake for resident #028.
-The Nutrition and Hydration Flow Sheet for a thirteen day period in a specified month indicated that resident #023 had refused or slept through 20 out of 39 (51 per cent) meals including three consecutive days with poor intake. No request for nutrition consultation was found in the documentation regarding poor intake for resident #028.

Review of Nutrition Policies and Procedures in the home identified the following:
a) The Request for Nutrition Consultation Tab 07-41 indicated reason for referral "No food intake for >48 hours or < 50% intake of meals for three consecutive days and otherwise provided no direction regarding referrals for poor food intake.
b) The RD Referral Cheat Sheet dated April 2016 which was used during education sessions with staff did not reference making referrals to the RD for refusal of meals or poor food intake.
c) The Nutrition and Hydration Policy Tab 04-46 did not reference making referrals to the RD for refusal of meals or poor food intake.

During an interview with a Nurse Consultant, it was reported that the registered team lead was responsible for monitoring for poor intake. The Nutrition and Hydration policy Tab 04-46 was reviewed with the Nurse Consultant and it was acknowledged that the policies' focus was primarily on hydration and it did not provide direction regarding monitoring and evaluating food intake in the same way as fluids.

During an interview with a Registered Dietitian, it was reported that they did not receive referrals for poor food intake very often, but fluid intake referrals had improved. The RD acknowledged that poor food intake was not included on the RD tip sheet. The RD identified that policies in the home did not provide clear direction for staff regarding monitoring of poor food intake and the referral process for poor food intake.

The licensee failed to ensure the nutrition care program included the implementation of interventions to mitigate and manage the identified risks related to poor food intake.

The scope of this issue was a pattern and the severity of harm a level two - potential for actual harm. The compliance history was a level two - one or more unrelated noncompliance in the last three years. [s. 68. (2) (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 the nutrition care and hydration programs included the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services, to be implemented voluntarily.

Issued on this 21st day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568)
Inspection No. / No de l'inspection :	2016_325568_0016
Log No. / Registre no:	015521-16 / 013964-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 26, 2016
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF RIVERSIDE GLEN 60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bryce McBain

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that resident #023, #028, #001 and any other resident are offered a minimum of three meals daily; a between-meal beverage in the morning, afternoon and evening; and a snack in the afternoon and evening. When a resident is not available i.e. sleeping during the meal/snack, the resident is offered something to eat/drink when they wake up unless otherwise documented in the plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident is offered a minimum of, three meals daily; a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening.

1) Observations on a specified date at 0845 hours found resident #023 was not in the dining room for the breakfast meal and was observed to be sleeping in bed. At 0930 the resident was observed to still be in bed sleeping. At 1010 hours the resident was observed receiving morning care from a Personal Care Aide (PCA) but no food or fluids were observed being offered by the PCA. Observations from 1010 to 1045 hours found resident #023 was not offered food or fluids from staff. At 1045 a PCA student who was delivering the snack cart offered resident #023 a drink, but did not offer food. Resident #023 refused to drink at that time and had no intake. Intake record for the specified date showed no food or fluid intake at breakfast and morning teacart.

On the specified date, a PCA reported that when resident #023 did not come for

breakfast they would usually offer them food and a drink when they woke up or something from the morning snack cart. The staff member said they did not usually offer a tray at breakfast for residents who did not attend, as it was too close to the morning snack cart. The PCA reported that they only use the "tray offered" row of the flow sheets for residents that don't usually miss breakfast.

On the specified date, the RPN Team Lead told inspector #630 that if a resident did not go to the dining room for lunch or supper they would usually save food from the meal and offer it later. At breakfast this practice occurred less often. The RPN said that in the morning something would be offered from the snack cart or a piece of toast prepared for the resident.

During observations on the specified date, resident #023 was not up for breakfast and was not offered a snack or toast later in the morning when they got up.

During an interview with the Director of Nursing (DON) and Nurse Consultant, it was reported that staff were expected in the home to offer tray service to residents not in the dining room at a meal and that intake would be documented on the Nutrition and Hydration Flow Sheets. The Nurse Consultant reported the home had implemented a "tray offered" row on the personal care observation and monitoring form to help monitor the trays that had been offered.

Review of the clinical record for resident #023 on the specified date, found the following:
-Nutrition and Hydration Flow Sheet for a one month period showed 13 out of 13 (100 per cent) breakfast meals the resident had no intake and was documented as "sleep" and no food offered; 10 out of 13 (77 per cent) morning teacart was documented as "sleep" and no food offered; four out of 13 (31 per cent) afternoon teacart was documented as "sleep" and no food offered; one out of 13 (8 per cent) dinner meals was documented as "sleep" and no food offered; and 12 out of 13 (92 per cent) evening teacart documented as "sleep" and no food offered.
- Documentation on the Nutrition and Hydration Flow Sheet for three days in the specified month showed that the only meal or snack where food was consumed was the lunch meal.
- The personal Care Observation and Monitoring form for the first fourteen days of the month showed no tray service offered on any of these days.
- Plan of care for resident #023 identified them as being a "High Nutritional Risk".

It did not identify sleeping through meals, or provide direction for staff if the resident slept through a meal or a snack. No specialized snacks for morning teacart were identified as part of the plan of care.

A Registered Dietitian told inspector #630 that it was the expectation of the home that for residents who slept through breakfast they would be offered a tray or a special higher calorie snack in order to help meet their nutrition and hydration needs.

The Director of Hospitality and Food Services and Food Services Manager (FSM) told inspector #630 and #568 that the resident's life plan should indicate whether the resident preferred to sleep through meals and snacks. It was also reported that residents who missed the regular breakfast service should be offered a meal later in the morning through tray service. The FSM reported that there was no tracking system in place that they were aware of in terms of when trays were requested or offered to residents.

2) Review of a Critical Incident (CI) report found that the Neighbourhood Coordinator (NC) had assessed the nutritional intake documentation of an identified resident at 1530 hours and it was documented that the resident was sleeping in the morning and not fed. Further, morning snack and lunch were left unrecorded. The resident was noted by the charge nurse as alert and awake throughout the day. The NC called the team lead and the PCA responsible and they confirmed no nutrition was offered.

During observations by inspector #568 on a specified date, it was noted that the identified resident was not brought to the dining room for the evening meal until 1750 hours. Many of the residents had finished their meal and left the dining room.

A PCA told the inspector that the resident's nutritional intake had decreased over the past couple of weeks and their care needs had changed. They said that residents who slept through breakfast or who were not up for breakfast were usually offered trays. Their role in the dining room was to order and help prepare the trays, but usually it was another staff who delivered the trays. The PCA said they could not recall whether a tray was prepared and offered to the identified resident during the two specified days.

A second PCA told the inspectors that the identified resident had been missing

for breakfast. A Registered Practical Nurse (RPN) reported to the inspector that the days before the identified resident's health status changed they were having more difficulties attending meals. The RPN reported an awareness that the resident was not going down for meals. The RPN believed that the resident was being offered a tray by the PCAs when they didn't attend meals.. The RPN acknowledged that they did not double check whether the resident was being fed and did not usually check the Food and Nutrition Flow Sheets at the end of the shifts.

Review of the clinical record for the identified resident on a specified date, found the following:
-Nutrition and Hydration Flow Sheet for the month, showed seven out of 13 (54 per cent) breakfast meals the resident had no intake and was documented as "sleep" and no food offered; 13 out of 13 (100 per cent) morning teacart was documented no food offered; seven out of 13 (54 per cent) lunch meals the resident had no intake and was documented as refused; 13 out of 13 (100 per cent) afternoon teacart was documented as no food offered; and 12 out of 13 (92 per cent) evening teacart documented as no food offered.
- Nutrition and Hydration Flow Sheet showed that on two days during that month the resident had no food intake. On another day the only meal or snack where food was consumed was the dinner meal and the resident was coded as having consumed "1/4" of the protein item. Documentation on another day indicated that the only meal or snack where food was consumed was the afternoon cart and the resident was coded as having consumed "1/4" of the snack item.
- The personal care observation and monitoring form for a one week period during the month showed no tray service offered on any of these days.
- Plan of care identified the resident as having "Moderate Nutritional Risk" due to potential for inadequate nutritional intake but did not identify sleeping through meals or direction for staff if the resident slept through a meal or a snack. No specialized snacks for morning teacart were identified as part of the plan of care.

3) Review of resident #001's plan of care related to nutrition and hydration identified that the resident was a high nutritional risk related to poor intake of food plus refusals. The resident was reported to enjoy a specified item at breakfast and if meals were refused the resident was to be provided with an alternate.

Record review identified that resident #001 had no intake at breakfast on nine out of the first twelve days in the identified month. On three of those days it was

documented that the resident was sleeping. On two of the twelve days the resident refused. During the morning tea cart for the same twelve days there was no documentation that the resident had anything to eat and on four of the twelve days they had no fluids in the morning.

On a specified date, resident #001 was observed in their room sleeping at 0830 and 0845 hours. At 0930 hours the resident was sitting dressed in their room. There was no sign of a tray in the resident's room.

During an interview with a PCA they reported that the resident's food and fluid intake was documented on the Nutrition and Hydration Flow Sheet following each meal and snack cart. If a resident refused then this was also documented. The PCA that documents for a particular meal or snack flags those residents that do not come to the dining room so that a tray can be offered afterward. When the flow sheet documentation is blank for a meal or has a "nothing" sign then that would mean the resident did not eat that meal. A PCA stated that Resident #001 often slept through breakfast but would have a snack when they got up. When shown the Nutrition and Hydration Flow Sheet for resident #001 the staff member acknowledged that there was no documentation that the resident was offered breakfast or a morning snack/beverage on a number of days in the specified month including the observation day. (#568)

The licensee has failed to ensure that each resident was offered a minimum of, three meals daily; a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening.

The scope of this issue was a pattern and the severity of harm a level two with a potential for risk or harm to residents. The home had a history of non-compliance with this subsection of the regulation. It was issued as a Voluntary Plan of Correction on January 19, 2016 during the Resident Quality Inspection and issued again as a Voluntary Plan of Correction on March 17, 2016. (568)

2. 2) Review of a Critical Incident (CI) report found that the Neighbourhood Coordinator (NC) had assessed the nutritional intake documentation of an identified resident at 1530 hours and it was documented that the resident was sleeping in the morning and not fed. Further, morning snack and lunch were left unrecorded. The resident was noted by the charge nurse as alert and awake throughout the day. The NC called the team lead and the PCA responsible and they confirmed no nutrition was offered.

During observations by inspector #568 on a specified date, it was noted that the identified resident was not brought to the dining room for the evening meal until 1750 hours. Many of the residents had finished their meal and left the dining room.

A PCA told the inspector that the resident's nutritional intake had decreased over the past couple of weeks and their care needs had changed. They said that residents who slept through breakfast or who were not up for breakfast were usually offered trays. Their role in the dining room was to order and help prepare the trays, but usually it was another staff who delivered the trays. The PCA said they could not recall whether a tray was prepared and offered to the identified resident during the two specified days.

A second PCA told the inspectors that the identified resident had been missing for breakfast. A Registered Practical Nurse (RPN) reported to the inspector that the days before the identified resident's health status changed they were having more difficulties attending meals. The RPN reported an awareness that the resident was not going down for meals. The RPN believed that the resident was being offered a tray by the PCAs when they didn't attend meals.. The RPN acknowledged that they did not double check whether the resident was being fed and did not usually check the Food and Nutrition Flow Sheets at the end of the shifts.

Review of the clinical record for the identified resident on a specified date, found the following:
-Nutrition and Hydration Flow Sheet for the month, showed seven out of 13 (54 per cent) breakfast meals the resident had no intake and was documented as "sleep" and no food offered; 13 out of 13 (100 per cent) morning teacart was documented no food offered; seven out of 13 (54 per cent) lunch meals the resident had no intake and was documented as refused; 13 out of 13 (100 per cent) afternoon teacart was documented as no food offered; and 12 out of 13 (92 per cent) evening teacart documented as no food offered.
- Nutrition and Hydration Flow Sheet showed that on two days during that month the resident had no food intake. On another day the only meal or snack where food was consumed was the dinner meal and the resident was coded as having consumed "1/4" of the protein item. Documentation on another day indicated that the only meal or snack where food was consumed was the afternoon cart and the resident was coded as having consumed "1/4" of the snack item.

- The personal care observation and monitoring form for a one week period during the month showed no tray service offered on any of these days.
- Plan of care identified the resident as having "Moderate Nutritional Risk" due to potential for inadequate nutritional intake but did not identify sleeping through meals or direction for staff if the resident slept through a meal or a snack. No specialized snacks for morning teacart were identified as part of the plan of care.

3) Review of resident #001's plan of care related to nutrition and hydration identified that the resident was a high nutritional risk related to poor intake of food plus refusals. The resident was reported to enjoy a specified item at breakfast and if meals were refused the resident was to be provided with an alternate.

Record review identified that resident #001 had no intake at breakfast on nine out of the first twelve days in the identified month. On three of those days it was documented that the resident was sleeping. On two of the twelve days the resident refused. During the morning tea cart for the same twelve days there was no documentation that the resident had anything to eat and on four of the twelve days they had no fluids in the morning.

On a specified date, resident #001 was observed in their room sleeping at 0830 and 0845 hours. At 0930 hours the resident was sitting dressed in their room. There was no sign of a tray in the resident's room.

During an interview with a PCA they reported that the resident's food and fluid intake was documented on the Nutrition and Hydration Flow Sheet following each meal and snack cart. If a resident refused then this was also documented. The PCA that documents for a particular meal or snack flags those residents that do not come to the dining room so that a tray can be offered afterward. When the flow sheet documentation is blank for a meal or has a "nothing" sign then that would mean the resident did not eat that meal. A PCA stated that Resident #001 often slept through breakfast but would have a snack when they got up. When shown the Nutrition and Hydration Flow Sheet for resident #001 the staff member acknowledged that there was no documentation that the resident was offered breakfast or a morning snack/beverage on a number of days in the specified month including the observation day. (#568)

The licensee has failed to ensure that each resident was offered a minimum of, three meals daily; a between-meal beverage in the morning and afternoon and a

beverage in the evening after dinner; and a snack in the afternoon and evening.

The scope of this issue was a pattern and the severity of harm a level two with a potential for risk or harm to residents. The home had a history of non-compliance with this subsection of the regulation. It was issued as a Voluntary Plan of Correction on January 19, 2016 during the Resident Quality Inspection and issued again as a Voluntary Plan of Correction on March 17, 2016.
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_325568_0011, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

The licensee shall ensure that where bed rails are used;
(i) the resident is assessed and ;
(ii) his or her bed system evaluated in accordance with evidence-based practices to minimize risk to the resident, including when there has been a change to the resident's bed system.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

This was a follow-up to an order issued April 18, 2016, under log #008065-16 inspection #2016_325568_0011 with a compliance order date of May 20, 2016. The order included that where bed rails were used; the resident was to be assessed and his or her bed system evaluated in accordance with evidence based practices to minimize risk to the resident, including when there was a change to the resident's bed system. The home was to ensure that there was an organized method to track changes to resident's bed systems.

During observations on two consecutive days of the inspection, it was noted that resident #010 had a bed rail up on their bed.

The Director of Environmental Services (DES) shared that the home had instituted a new process for the assessment of bed systems and this process was now coordinated by the environmental services department. All beds in the home were assessed annually by an external contractor. Most recently they were assessed in April 2016. Any beds that did not pass any of the potential zones of entrapment were highlighted and the home addressed the individual concerns. Once changes were made to the beds they were retested to ensure that they passed. Any time a change is made to the bed system including the addition of bed rails or change in mattress type a maintenance requisition would be sent using their electronic system. The maintenance staff receive these requisitions and followup. When they reassess a bed the maintenance staff complete a Schlegel Villages Bed Entrapment audit form which records the room number, specific features of the bed system, use of bed rails and the results of the entrapment testing for zones 1-7. The audit is signed and dated by maintenance staff. If any zone fails testing then the DES and the DON are notified and actions taken to correct the failed zones are also documented. These forms are kept in the Bed Entrapment binder.

During an interview with a Registered Practical Nurse they reported that resident #010 had a bed rail up on their bed. The resident used the bed rail to assist with their activities of daily living. The RPN indicated that family had requested that the resident have the bed rail, and that in these cases family sign a consent for the bed rail. The RPN was unable to locate a consent for the bed rail.

Review of resident #010's plan of care indicated that the resident used one bed rail when in bed. The most recent Bed Rail Assessment identified that resident #010 used a bed rail for assistance with their activities of daily living.

The current Bed Assessment Evaluation spreadsheet identified that the bed in resident #010's room had no bed rails. There were no Schlegel Villages - Bed Entrapment Audit forms found in the Bed Entrapment Binder for the bed system used by resident #010.

During an interview with the Director of Nursing they said they had followed up with the Director of Environmental Services regarding resident #010's bed and

they said there were no maintenance requests related to the bed system in that room. The most up to date information related to resident #010's bed would be the spreadsheet completed by the external consultant in April 2016. The DON acknowledged that resident #010's bed system had not been assessed with the bed rail.

The scope of this issue was isolated and the severity of harm a level two with a potential for harm to the resident. The home had a history of non-compliance with this subsection of the regulation. A compliance order was issued on March 17, 2016 with a compliance date of May 20, 2016.
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_448155_0002, CO #001;

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 home shall ensure that the following plans, policies, protocols, procedures, strategies or systems instituted or otherwise put in place are complied with specifically related to:
a) Nutrition and Hydration policy in regards to documentation of the food and fluid intake of residents, including appropriate supplements, on flow sheets at the time of meal and snack service; nutrition and hydration flow sheets being tallied, reviewed and initialed by the Registered Practical Nurse/Registered Nurse, residents identified at risk of dehydration are being offered additional fluids and these are being documented as part of the residents food/fluid intake, dehydration risk assessment tools being completed as per policy; and requests for nutrition consultation are being completed as per policy.
b) Weight and Height Monitoring policy with regards to reweighs for residents identified as having a significant weight loss or gain and documentation of these reweighs as per the policy.
c) Spa (Shower, tub Bath, Sponge Bath) policy in regards to the documentation of the type of spa provided, level of assistance provided on the PSW flow sheet, including skin assessment and if concerns identified. If the resident declined their spa it is to be documented as per policy.
d) Pain Management policy in regards to completion and documentation of pain assessments as per the policy.

Grounds / Motifs :

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

This was a follow-up to an order issued March 17, 2016, under log #000864-16 inspection #2016448155_0002 with a compliance order date of May 16, 2016. The order included that the home would prepare, submit and implement a plan to ensure that plans, policies, protocols, procedures, strategies or systems instituted or otherwise put in place related to Fall Prevention and Management, Nutrition and Hydration, Weight and Height Monitoring, Head Injury Routine, Spa, Personal Care Ware, Food Temperature Control, and Catheter were complied with.

The home's policy titled "Weight and Height Monitoring" Tab 04-76 dated August 2015, indicated that when a monthly weight identified a weight loss or gain of two kilograms (kg) from the previous month a reweigh would be completed and all weights would be documented electronically in the Village Software. It also indicated that when a monthly weight identified a weight loss or gain of two kilograms (kg) from the previous month, a reweigh would be completed and when unplanned weight change was identified the Team Leader would be notified and a complete a Request for Nutrition Consultation.

Review of the weights recorded in the village software for a specified Neighbourhood found that for a ten week period, six out of thirty-two residents (19 per cent) in this area had a weight loss or gain of two kilograms from the previous month and no reweigh was documented electronically in the village software. Review of the clinical record for resident #024 identified a two point seven kilogram (five point one per cent) weight loss over one month. There was no documentation of a reweigh for resident #024 and no referral to the Registered Dietitian.

Review of the weights recorded in the village software for a second Neighbourhood found that for the same ten week period, 10 out of 32 residents (31 per cent) in this area had a weight loss or gain of two kilograms from the previous month and no reweigh was documented electronically in the village software.

Review of the weights recorded in the village Software for a third Neighbourhood

found that for the ten week period, six out of 32 residents (19 per cent) in this area had a weight loss or gain of two kilograms from the previous month and no reweigh was documented electronically in the village software.

During an interview with a PCA they reported that there was a weight sheet that they wrote the weights on once a month, as well as if there was a reweigh needed. The PCA reported they do reweighs if a resident's weight was different from the previous month by two kilograms or if the nurse told them to reweigh a resident.

During an interview with a RPN it was reported that there was a weight sheet that the PCAs used to record the weights on, prior to the registered staff entering it into the village software. The RPN said a reweigh was done if a resident was up or down two kilograms or if requested by nursing or the RD based on the previous weight. The RPN said the reweighs should be added into village software, in addition to the original weight.

During an interview with a RD they said that the weights were taken each month for residents at the beginning of the month and then entered into the village software. The RD reported that they rely on the electronic weight record for the weights when doing assessments. They said they had been receiving referrals for weight loss but were still identifying residents who had weight loss of more than two kilograms in a month with no referral received.

The home failed to ensure that the Weight and Height Monitoring policy was complied with. (#630) (568)

2. The home's policy titled "Nutrition and Hydration", Tab 04-46 dated April 2014, indicated that each evening the Nutrition and Hydration Flow Sheets would be tallied by the night Personal Care Aide (PCA) team, which would include the Daily Additional Fluids Chart. The night Registered Practical Nurse/Registered Nurse would review and initial the total daily fluid intake. Any resident who had a fluid intake less than their estimated fluid requirement would be reported to the oncoming RPN/RN so that interventions could be initiated. Commercial supplements would be documented on the MAR and the Daily Additional Fluids Charts. Interventions would include additional fluids being encouraged at each meal and via the Teacarts. Extra fluids consumed by the resident would be documented by the RPN/RN at medication pass on the Daily Additional Fluids chart. The RPN would assess signs and symptoms of

dehydration using the Dehydration Risk Assessment Tool. The Request for Nutritional Consultation would be completed when a resident had a fluid intake of less than 1000 mls or per individual fluid requirement as per the Plan of Care for three (3) consecutive days and there was at least one sign or symptom of dehydration present. The policy also indicated that the Nutrition and Hydration Binder would be placed on the Teacart at the time of each nourishment service. Food and fluid intake would be documented at the time of service.

a) A review of the July 2016 Nutrition and Hydration Flow Sheet for resident #023 showed there were no RPN/RN initials for 11 out of 11 days (100 per cent). This review also showed that fluid intake from the additional fluids chart was not completed on the flow sheet for nine out of eleven days (82 per cent). A review of the July 2016 Daily Additional Fluids Charts found resident #023 was not included on the list for 11 out of 12 days (92 per cent). Resident #023 was included on the list on one of the days, but this record was incomplete as it only included fluids taken at 0800 hours and 1200 hours and did not include the total.

Observations at the lunch meal on a specified date in July found that resident #023 consumed some of the nutritional supplement that was provided by the RPN but then refused to drink more. Review of the additional fluids on the Nutrition and Hydration Flow Sheet for the specified date showed the intake of this supplement was not identified on the record.

During an interview with a RPN it was reported that resident #023 had fluctuating fluid intake but usually did consume the supplement when offered. Resident #023 did not accept the full amount prescribed at lunch on the specified date. The RPN said that the Daily Additional Fluid Chart was only used for residents who had an intake less than their required amount. Review of the July 2016 Daily Additional Fluid Charts with the RPN identified that resident #023 was only included on this chart on one day in July and the documentation was incomplete.

During an interview with a Registered Dietitian (RD) they reported that nutritional supplements were to be included in the additional fluids section of the Nutrition and Hydration Flow Sheets. Review of the records for resident #023 with the RD indicated that the additional fluids were not completed as per the home's policy.

During an interview with the Nurse Consultant they indicated that the direction given to staff during the education sessions was different than the process specified in the home's policy. The Nurse Consultant said that the "Daily Additional Fluids" did not include supplements unless a resident was at high risk for poor fluid intake and that the registered staff were directed to only initial the sheets if they had been notified of a poor fluid intake.

During an interview with the Food Services Manager they said that it was the home's expectation that registered staff would review and sign the Nutrition and Hydration Flow Sheet on a daily basis. (#630)

b) Review of the plan of care for resident #003 for Dehydration/Fluid Maintenance identified the resident as being a concern related to insufficient fluid intake. Interventions to address this concern included offering the resident fluids they enjoy; assessing skin turgor for dryness and slow reaction time; ensuring that when the resident did not meet their daily fluid requirements for 3 days in a row that a dehydration risk assessment was completed to monitor for signs/symptoms of dehydration.

Record review revealed the Dehydration Report for a specified month and neighbourhood. The report identified resident #003's estimated daily fluid requirement. Documentation of the daily fluid intake for resident #003 was below the estimated requirement on four consecutive days in the specified month. The resident was listed on the Daily Additional Fluids Chart for two of the four days. Records did not reveal a Dehydration Risk Assessment for resident #003 and there was no documentation of a request for nutritional consultation.

During an interview with a Registered Dietitian they indicated that when a resident has a fluid intake below their minimum level for three consecutive days then nursing staff complete a Dehydration Risk Assessment. If there are any signs or symptoms of dehydration then they are to make a referral to the RD. The RD was shown the Dehydration Report for the specified neighbourhood and they agreed that resident #003's intake was below their minimum requirement for four consecutive days. The RD said that at a minimum the resident should have had an assessment. They had no record that resident #003 had been referred for a nutrition/hydration consult.

The Assistant Director of Nursing (ADON) acknowledged that resident #003 had

a fluid intake below their minimum requirement for four consecutive days in the specified month. After reviewing the clinical record for resident #003, the ADON stated that there was no Dehydration Risk Assessment completed and no referral to the Registered Dietitian as outlined in the home's policy. In addition, the ADON acknowledged that registered staff had not documented that they had reviewed the total daily fluid intake of residents by initialing on the Nutrition Hydration Flow Sheets. (568)

c) Observations on a specified date on one of the neighbourhoods from 1510 hours to 1530 hours found two PCAs serving food and fluids from the nourishment cart to residents in the lounge and then the cart was put away. The Nutrition and Hydration Binder was observed in the dining room not on the Teacart. PCAs were not observed recording the intake of residents at the time of service. The additional fluids section of the Nutrition and Hydration Flow Sheets was found to be incomplete for all residents at the time of observations.

The Food Services Manager (FSM) acknowledged that the Nutrition and Hydration Flow Sheets were not completed at the time of service as per the home's policy.

Observations on a specified date found a PCA student serving food and fluids to residents on one of the home neighbourhoods. No staff of the home were observed to be with the student during this time. The Nutrition and Hydration Binder was observed on the nursing station not on the Teacart. The PCA student was not observed to record the intake of residents at time of service. (#630)

The licensee failed to ensure that the Nutrition and Hydration policy was complied with. (568)

3. The home's policy titled "Pain Management Program" dated November 6, 2015, identified under the procedure for registered staff that they would complete and document a pain assessment on initiation of a pain medication or PRN analgesic, when there are personal expressions exhibited by the resident that may be an indicator of the onset of pain and when there is a change in condition with pain onset.

Review of the progress notes for resident #028 identified that on a specified date at approximately 1000 hours a Personal Care Aide reported that the resident

had an area of altered skin integrity. The resident presented with some discomfort on movement of the area. Analgaesics were given by mouth for pain. A skin concern form was completed and noted in the TAR to monitor. Two days later a PCA mentioned that the resident was exhibiting signs of pain with movement. PRN analgaesics were given as per the medical directives. Four days later the resident complained of pain in the same area when touched and there were further signs of altered skin integrity. The resident refused to take medication by mouth and the analgaesics were given in a different form. Seven days after the initial reports of pain, the registered staff was alerted to the resident complaining of pain. The resident refused medication for pain and the resident was transferred to hospital for further evaluation.

During an interview with two PCAs they shared that resident #028 had been exhibiting signs and symptoms of pain since two areas of altered skin integrity were identified two weeks previous. The resident also demonstrated a change in care needs during this period of time. The PCAs stated that they had reported these changes to the registered staff on duty.

Clinical record review identified an Abbey Pain Scale completed six days after the initial pain was reported. There were no pain assessments completed for resident #028 when they first reported pain and when they were first given PRN analgesics.

During an interview with a RPN they indicated that when a resident reports a new pain they would usually assess using the Abbey pain Scale or the Face Pain Scale. The RPN acknowledged that they had not completed a pain assessment for resident #028 when the pain was first reported.

The licensee failed to comply with their Pain Management policy. (568)

4. The home's policy titled "Spa (Shower, tub Bath, Sponge Bath) dated February 2016 indicated that staff are to document the type of spa provided and the level of assistance provided on the PSW Flow Sheet, including nail and skin care. When a Resident declines their spa after multiple attempts and negotiation, it must be documented on the PSW Flow Sheet under 'Bathing' as well as in the 'Behavior' section or in the Electronic Health Record if the village is paper free. The PCA will report this refusal to the Team Leader and the Team leader will document the reason for refusal and alternative interventions tried

without success. If a resident refuses today, offer their spa the following day, or later in the shift.

a) The care plan for resident #023 with respect to bathing identified that the resident required extensive assistance for bathing. The Personal Care Observation and Monitoring Forms for a three week period identified that resident #023 was bathed four times. During two of the three weeks the resident received just one shower/bath and there was no documentation to indicate that the resident had either refused their shower/bath or was not available on the other days. Progress notes for the same period did not identify that the resident had refused their bath/shower, and if they had, what alternative interventions were tried.

During an interview with a Personal Care Aide (PCA) they indicated that resident #023 usually had a shower/bath twice a week. It was rare that the resident refused but on occasion due to staffing they may not have been able to complete the resident's shower/bath. In this situation the bath/shower would be moved to the next day. When a resident refused staff should document on their flow sheet and notify the registered staff. When shown the Personal Care Observation and Monitoring forms for resident #023 during the three week period the PCA acknowledged that there was no documentation to indicate that the resident had a shower/bath twice a week during this time. The PCA indicated that it was possible the resident had their shower/bath but it was not documented.

During an interview with a Registered Practical Nurse they reported that residents were given either a bath or shower twice each week unless otherwise indicated on their plan of care. If a resident refused their bath/shower, staff were to document on the flow sheet and let the registered staff know. The RPN acknowledged that there was no documentation on the PCA flow sheets to indicate that resident #023 was given a bath/shower twice a week during the three week period, and there was no documentation of refusal or the resident not being available.

b) The care plan for resident #001 with respect to bathing identified that the resident required extensive assistance for bathing. The resident would usually have a shower/bath and have their hair washed at this time. The Personal Care Observation and Monitoring Forms for a three week period identified that resident #001was given three showers/baths. During one of the three weeks

documentation indicated that the resident did not have a bath or shower. There was no documentation to indicate that the resident had either refused their shower/bath or was not available. There was no documentation in the progress notes for the same period to indicate that the resident had refused their bath/shower, and if they had, what alternative interventions were tried.

During an interview with a Personal Care Aide (PCA) they indicated that resident #001 had a shower/bath twice a week. If the resident refused their shower/bath or the staff were unable to conduct it for some reason this would be documented on the Personal Care Observation Flow sheets that PCA staff complete every day. They would also alert the charge nurse who would inform the family if there were ongoing issues. When shown the Personal Care Observation and Monitoring forms for resident #001 during the three week period the PCA acknowledged that there was no documentation to indicate that the resident had a shower/bath twice a week. The PCA indicated that they were fairly sure the resident had a shower/bath more often but it may not have been documented.

During an interview with a Registered Practical Nurse they reported that residents were given either a bath or shower twice each week unless otherwise indicated on their plan of care. If a resident refused their bath/shower, staff were to document on the flow sheet and let the registered staff know. The RPN acknowledged that there was no documentation on the PCA flow sheets to indicate that resident #001 was given a bath/shower twice a week during the three week period and there was no documentation of refusal or the resident not being available.

The licensee failed to ensure that the Spa policy was complied with.

The scope of this issue was a pattern and the severity of harm a level two - potential for actual harm. The compliance history was a level four - despite Ministry of health action (VPC, Order) non-compliance continues with original area of noncompliance. The compliance history identified that a Voluntary Plan of Correction was issued previously during the following inspections: October 17, 2013 related to the Nutrition and Hydration, bathing and restorative dining policies; November 7, 2013 related to the Falls Prevention and Management policy; April 14, 2014 related to the Weight Monitoring policy; April 22, 2014 related to the Catheter policy; May 21, 2014 related to the Nutrition and Hydration policy; June 4, 2014 related to the hiring policy; August 1, 2014 related to the Medication Administration policy; October 15, 2014 related to the

Nutrition and Hydration and Lost Items policies; November 20, 2014 related to the Skin and Wound policy; December 14, 2014 related to the Skin and Wound policy; April 14, 2015 related to the Weight and height Monitoring, Admission of Residents and Fall Prevention/Management policies; December 16, 2015 related to the Prevention of Abuse policy. During a Resident Quality Inspection on May 11, 2015 a compliance order related to Weight and Height Monitoring and Personal Assistance Safety Device policies was issued. This order was complied on September 13, 2015.

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_325568_0011, 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 ensure that:
(i) where a resident is identified in the plan of care as requiring a supplement, the supplement is provided to the resident as set out in the plan of care, and the intake of the supplement is documented;
(ii) the plan of care with respect to the use of bed rails is provided to the resident as specified in the plan.

Grounds / Motifs :

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

This was a follow-up to an order issued April 18, 2016, under log #008065-16 inspection #2016_325568_0011 with a compliance order date of May 20, 2016. The order included that where a resident was identified in the plan of care as requiring a supplement, the supplement was provided to the the resident as set out in the plan of care, and the residents intake of the supplement was documented.

Review of the plan of care for resident #009 indicated that no bed rails were required at the present time and therefore the resident was considered a low risk for bed rail entrapment/injury. The bed rail assessment indicated that the resident had no bed rails and was low risk.

During observations on two consecutive days during the inspection, it was noted that resident #009's bed had a bed rail up.

During an interview with a Personal Care Aide they shared that resident #009 had a bed rail up for safety. When asked how staff were informed as to what type of bed rails, if any, a resident would have, the staff member stated that this would be outlined in the resident's plan of care, which staff can access in their binders.

The RAI/QI staff stated that resident #009 should not have any bed rails raised on their bed as per their bed rail assessment and care plan. The staff member was shown resident #009's bed with the bed rail up. The RAI/QI staff was unsure why the bed rail was up and acknowledged that care was not being provided as set out in the plan.
(568)

2. Review of resident #001's plan of care identified the resident as a high nutritional risk. Orders documented by the Registered Dietitian and outlined in the care plan related to nutrition/hydration indicated that resident #001 was to be provided with a nutritional supplement at each medpass and at an identified snack.

The medication administration record (MAR) identified that the nutritional supplement was to be given three times daily at medpass and another supplement at the identified snack. For the first eleven days of the specified month documentation indicated that the nutritional supplement had been given three times on nine of the eleven days. On two of the days there was no documentation at the noon med pass that the resident received their supplement. In terms of the supplement that was to be given at snack, it was documented that the resident refused on eleven of the eleven days.

During an interview with a RPN they reported that it was the registered staff's responsibility to ensure the residents had their supplements if they appear on the medication administration record. When asked what the direction was for resident #001 in terms of their snack supplement, the RPN stated that it was to be given at the time of snack cart. The RPN acknowledged that the documentation in the MAR indicated that the resident had refused their snack supplement for the first eleven days of the specified month.

The Registered Dietitian shared that supplements are listed on the MAR with the exception of one specific kind. Registered Staff are expected to sign off on the

supplement when it is given. In terms of resident #001, the RD was asked to clarify the order for the snack supplement. The RD stated that this order indicated that the resident was to be given the supplement at the time of the identified snack service. When shown that the resident had refused the supplement for the first eleven days of the specified month, the RD stated that the registered staff should have sent a referral to them indicating that the supplements were not being given. The Assistant Director of Care and RN acknowledged that the nutritional supplement had not been given to resident #001 as indicated in the plan of care. Registered staff should have notified the Registered Dietitian of the repeated refusals given that the resident was a high nutritional risk.

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 for resident #001 with respect to their nutritional supplement, and resident #009 with respect to bed rails.

The scope of this issue was isolated and the severity of harm a level two - potential for harm to residents. The home had a history of non-compliance with this subsection of the regulation. A compliance order was issued on April 14, 2014, with a compliance date of May 2, 2014. The order was complied on July 24, 2014. A Voluntary Plan of Correction was issued during inspections on October 15, 2014 and May 11, 2014.
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall protect residents from neglect by staff and ensure that changes in a resident's condition including a decline in transfer status, increased pain, reduced intake, and skin concerns, including bruises, are communicated, documented by all staff, and that there is a process in place to ensure that the resident is reassessed and interventions in place to address these concerns.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from neglect by staff in the home.

O.Reg 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident report described an incident where a resident was not fed on a specified morning because they were sleeping; and there was no documentation to indicate the resident was given a morning snack or lunch on the same day. The Charge Nurse and Personal Care Aide assigned to the resident confirmed that no nutrition had been offered to the resident at breakfast, morning snack and lunch on the specified day. The CI was updated to indicate that resident #028 had declined medication and nourishment through the night and the following day, at which point they were transferred to hospital.

Review of the resident's plan of care identified that they were a moderate nutritional risk due to the potential for inadequate nutritional intake. The plan of care did not identify that the resident frequently slept through meals / snacks.

The resident was identified as requiring assistance from staff for transfers.

Review of the progress notes for a two week period prior to the resident's transfer to hospital identified that PCAs had reported areas of altered skin integrity, verbal and physical expressions of pain, as well as changes in the identified resident's care needs to the RPN in charge. During interviews with several Personal Care Aides they reported that they had observed a decline in the identified resident's nutritional intake as well as a change in their care needs over the ten to fourteen day period prior to their transfer to hospital. The same staff stated that they had reported these changes as well as the resident's expressions of pain and changes in the altered skin integrity to registered staff, as well as management of the home. There was no documentation during the initial week following the identification of pain and altered skin integrity that the resident was assessed or that a referral was made for further evaluation of the concerns.

The Nutrition and Hydration Flow Sheet for the specified month, showed seven out of 13 (54 per cent) breakfast meals where the resident had no intake and was documented as "sleep" and no food offered; 13 out of 13 (100 per cent) morning teacarts where it was documented that no food was offered; seven out of thirteen (54 per cent) lunch meals the resident had no intake and was documented as refused; 13 out of 13 (100 per cent) afternoon teacarts where it was documented that no food was offered; and 12 out of 13 (92 per cent) evening teacarts where it was documented that no food was offered.
- Nutrition and Hydration Flow Sheet showed on two days during the month that the resident had no food intake. On one of the days, the only meal or snack where food was consumed was dinner and the resident was coded as having consumed "1/4" of the protein item. On another day, the only meal or snack where food was consumed was the pm cart and the resident was coded as having consumed "1/4" of the snack item.

A Skin Assessment Concerns form was completed on the specified date by the RPN. The form identified the resident as having two areas of altered skin integrity. It was also noted that the protocol was written in the TAR and that electronic documentation had been completed. The Skin Assessment Concerns form was signed off by the RAI/QI five days later. The Personal Care Observation and Monitoring Form indicated that there were no skin concerns identified during spa days by the PCA staff even after the altered skin integrity had been reported to registered staff.

During an interview with the RPN they shared that they were first alerted about a concern with the identified resident, seven days before they went to hospital. A Personal Care Aide brought to their attention that the resident had two areas of altered skin integrity. The staff member also told them that the resident was complaining of pain. When they assessed the resident they noted areas of altered skin integrity. The RPN stated that they could tell the resident was in discomfort from their expression. The RPN told this inspector that they notified the charge nurse (CN) who advised that they would come to assess. Because it was the end of the shift the RPN was unsure if the CN came. The RPN stated that the resident was given medication for pain and a Skin Concern form was completed. The areas of altered skin integrity were added to the TAR. The RPN could not recall the resident exhibiting signs of pain after the day the concern was first brought to their attention. When asked if other staff had reported the altered skin integrity, pain, or other changes related to the resident, the RPN stated that nothing was mentioned until six days later when it was reported that the resident had extreme pain. Upon further questioning, the RPN stated that someone might have mentioned the altered skin integrity when the resident was bathed at which time they checked on the resident and things were healing normally. The RPN stated that it was their practice to visualize the area of altered skin integrity each day before signing the TAR. Because there were no changes other than normal healing they did not document in the progress notes or alert other staff. The RPN reported that it was not until six days after they first assessed the resident that staff reported a change in the resident's care needs. The RPN acknowledged that they had noted that the resident had not been getting up for meals as much but they assumed they were getting a tray. When asked if the RPN reviewed the Nutrition and Hydration flow sheets to look at residents intakes the RPN said that sometimes they do but not always. The RPN did not recall looking at the identified resident's Nutrition Hydration flow sheet. In terms of the resident's pain, the RPN stated that usually the resident's pain would be assessed when the area of altered skin integrity was assessed. The RPN stated that they would do the Abbey Pain Scale after giving pain medication and document the response. The RPN acknowledged that they should have done a pain assessment when the resident first complained of pain.

During a second interview with the RPN they acknowledged that the ADOC had approached them regarding the identified resident and asked that they reassess the resident. The RPN did not recall being advised to contact the charge nurse.

The RPN stated that they visualized the area of altered skin integrity and felt that it was resolving normally. At the time the resident was not complaining of pain and did not appear in any discomfort. When asked if the RPN conducted a physical assessment of the resident, the RPN could not recall.

The Neighbourhood Coordinator (NC) shared that they attend team meetings at shift change and and review progress notes in order to keep up to date on any resident changes. They said they were not aware of any concerns related to the identified resident until six days after the areas of altered skin integrity and pain were first documented. On that date, a PCA asked her to come to look at the resident. The NC stated that Assistant Director of Care was nearby and she asked her to come with her. Because of the resident's position and clothing it was difficult for the NC to visualize the area of altered skin integrity. The NC stated that the resident was upset and appeared in pain. The ADOC directed staff to put the resident back to bed and make them comfortable. Later that day the NC stated that she assisted a PCA with the resident's care. At that time they observed the altered skin integrity and noted that the resident was in pain while care was being provided. When asked if the NC had followed up with anyone regarding the observed altered skin integrity and pain observed, the NC stated that they didn't do anything until the following morning, at which point they called the Director of Nursing and asked them to assess the resident.

During an interview with the Assistant Director of Nursing (ADON) they stated that six days after the resident's pain and altered skin integrity were first documented, they were asked by the NC to look at the resident in light of concerns brought forward by a PCA. The ADON was not able to visualize the area of concern because of the resident's position and clothing, but it was obvious the resident was in pain. The ADON stated that they spoke with the RPN and asked them to assess for pain and to call the charge nurse. They also advised staff to put the resident back to bed. The ADON indicated that they did not circle back regarding this concern because they felt that clear direction had been given. The ADON reported to the inspector that there had been a notation about altered skin integrity approximately five days earlier on the nursing report, but it did not describe the area and nothing more was reported on subsequent days to indicate there was a concern.

During a telephone interview with a RN they confirmed that on a specified date they recalled being contacted by a RPN regarding the identified resident. The RN reports having gone to see the resident who was asleep. The RN stated that

they did not visualize the areas of altered skin integrity nor did they complete a physical assessment. The RN stated that they did not want to disturb the resident. The RN shared that they included the areas of altered skin integrity on the daily report.

A RPN was asked if any staff had brought to their attention specific concerns over the last month regarding the identified resident. The RPN said that about two weeks ago two Personal Care Aides came to her and said that the resident was complaining of pain and exhibiting facial grimacing during cares. The RPN recalls going to see the resident and observing one area of altered skin integrity. The staff member said that attempts to move the resident were met with reports of pain and grimacing. The RPN said that they gave the resident medication as per their PRN orders, wrote a note on their electronic system, and notified the oncoming nurse at shift report. When asked if the RPN had assessed the areas of altered skin integrity during any of their shifts in the last couple of weeks, the staff member stated that they were not aware that there was more than one area. When shown the MAR for two dates when the RPN worked they acknowledged that it was their signature on one of the days, indicating that they had monitored the areas of altered skin integrity. The RPN stated that they did not recall seeing this notation and only looked at the one area.

During an interview with a Registered Nurse they shared that on a specified date, six days after altered skin integrity and pain were first documented for the identified resident, while making rounds to the different home areas they were told by staff on one of the neighbourhoods that a resident had an area of altered skin integrity that was resolving. Staff reported that they were unsure how this condition had occurred. The following day the RPN called to report that the area of altered skin integrity had spread. The RN assessed the resident and based on their findings advised the RPN to contact the physician. The RN stated that there were areas of altered skin integrity and the resident was reporting pain during physical assessment. Staff reported to the RN that the resident had been requiring increasing assistance with their cares since the altered skin integrity had first been identified one week previous.

During an interview with the Director of Nursing they acknowledged that there was a problem with the documentation of skin assessments for the identified resident by the Personal Care Aides. The DON stated that it didn't make sense that the Personal Care Observation Monitoring form completed after documentation that the resident had altered skin integrity, indicated that the

resident had no skin concerns. In terms of evaluating the areas of altered skin integrity, the DON stated that it was the home's expectation that if the area of altered skin integrity changed in an unpredictable way then the staff member would notify the charge nurse. The DON acknowledged that if different people were evaluating the altered skin integrity it would be difficult to know if it had changed, if there was no documentation. The DON stated that it would seem that the resident's altered skin integrity had changed since it was first reported, but these changes were not captured by staff monitoring the resident's skin. The DON acknowledged that there were gaps in the communication, assessment, and documentation of concerns including pain, altered skin integrity, nutrition and activities of daily living for the identified resident. The DON agreed that staff at multiple levels had failed to follow-up on concerns that had been identified.

The licensee failed to protect the resident from neglect.

The scope of this issue was isolated and the severity of harm a level three with actual harm to the resident. The compliance history was a level three with one or more related non-compliance in the last three years. The home had a history of non-compliance with this subsection of the regulation. A Voluntary Plan of Correction was issued during an inspection on February 19, 2014. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 26th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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