Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Apr 2, 2015	2015_414110_0002	T-1725-15	Resident Quality Inspection

Licensee/Titulaire de permis

BARRIE LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

ROBERTA PLACE
503 ESSA ROAD BARRIE ON L4N 9E4

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

DIANE BROWN (110), GORDANA KRSTEVSKA (600), MATTHEW CHIU (565), VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 19, 20, 23, 24, 26, 27, March 2, 3, 4, 5, 6, 2015.

During the course of this inspection the following critical incident inspections T-2038-15 and T-2033-15 and a follow up the compliance order T-1227-14 were completed.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), assistant director of care(ADOC), staff educator-RAI-Coordinator, staff educator-continence care lead, environmental services manager (ESM), food service manager, activation - life enrichment coordinator, registered staff, laundry aide, personal support workers, activation aide and residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Sufficient Staffing

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

- **9 WN(s)**
- **5 VPC(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_168202_0013	202

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. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the hydration program includes the identification of any risks related to hydration as there is no clear direction to registered staff on monitoring and evaluating fluid intake and when to identify when a resident has not been consuming enough fluids.

Resident #15's plan of care revealed that staff are to monitor intake and output every shift.

Record review revealed that resident #15 required 1500mls fluids per day. The registered dietitian's (RD) initial assessment and care plan in month A, identified that staff were to encourage the resident to drink the 1500ml allotment daily as the resident was presently consuming 50% of 1500ml.
The quarterly review on an identified date, revealed that the resident's approximate fluid intake was 900ml/day which met 60% of his/her 1500ml fluid goal. Staff must offer and encourage the resident to drink the 1500ml allotment daily.
Further record review, revealed that the resident's fluid intake remained poor and less than 1500mls for several months. Resident was hydrated during a routine hospital visit.

A review and averaging of the resident's 24hr fluid intake- look back report revealed the following:

Average daily intake in month A = 522mls/day
Average daily intake in month B = 431mls/day
Average daily intake in month C = 393mls/day
Average daily intake in month D = 680mls/day
Average daily intake in month E = 644mls/day
Average daily intake in month F = 326mls/day

Review of the home' policy titled Nutrition Referral, version #2 dated- November 18, 2014, directs nursing staff to initiate a food service manager/dietitian referral of any concerns with a residents' intake for either food or fluid-especially if it appears to be an ongoing concern or is in anyway abnormal for that resident. Fluid standard used is "less than 75% of goal fluid intake for 3 consecutive days after being on Stop and watch".

Another policy guideline entitled Hydration Referral dated May 23, 2014, indicated that the night health care staff will total all residents intake each day for food and fluid from point of care (POC) and highlight residents who have had less than 50% of their calculated fluid needs for that day and place the information in the daily planner for next days and evening staff. Registered staff will communicate at morning shift report residents needing to be encouraged to drink more that day; monitor residents for 3 days. The night health care staff will identify when a resident has less than 50% of their calculated fluid needs in a 24 hour period for three consecutive days a referral will be made to the Food service Manager

Record review revealed that there were 39 occurrences of 3 consecutive days resident #15 was not consuming 50% of the daily hydration fluid goal or 53 occurrences of 3 consecutive days for not consuming 75% of the daily hydration fluid goal over a five month period.

Interviews with registered staff indicated that the nursing staff were aware that resident #15 was a poor drinker, but confirmed that they do not evaluate the daily fluid intake of residents.

The food service manager confirmed that from resident's admission and over the following five months, referrals related to decrease fluid intake have not been received.

An interview with the ADOC confirmed that registered nursing staff had not implemented the "stop and watch" component of the policy related to resident #15.

An interview with the DOC confirmed that the resident had not consumed 50% of the daily hydration fluid goal and that dietary referrals had not been sent to the RD. The DOC further indicated that it was the responsibility of the night nurse to print a report of fluid intake consumed for each resident and send a referral to the RD when fluids had been consumed at less than 50% for three consecutive days. The DOC confirmed that night staff had not been reviewing and monitoring residents' fluid intake and that no action had been taken when resident #15's intake was consistently below his/her required fluid needs. [s. 68. (2) (b)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is fully respected and promoted.

Resident #15 was admitted on an identified date, and assessed by the home's RD to be at high nutritional risk, a few days later,
Resident #15's fluid intake was assessed at 720mls/day, which reportedly met 48% of his/her 1500mls allotment daily. The nursing admission assessment identified resident #15 at risk for dehydration related to the resident not drinking all fluids offered.

The initial plan of care directed staff as follows:
Staff must offer and encourage resident to drink the 1500mls allotment daily.
To maintain adequate nutrition and individualized hydration.
Calculated fluid needs were 1450mls/day.

A review and averaging of the resident's 24hr fluid intake-look back report revealed the following:
Average daily intake in month A = 522mls/day
Average daily intake in month B = 431mls/day
Average daily intake in month C = 393mls/day

A review of the dietary quarterly and nursing assessment three months following admission, identified that the resident's approximate fluid intake was 900mls/day which met 60% of his/her 1500mls fluid goal and that nursing identified resident #15 at risk for dehydration related to the resident not drinking all fluids offered.
The plan of care continued to direct staff with the same approach to care as follows:
Staff must offer and encourage resident to drink the 1500ml allotment daily.
To maintain adequate nutrition and individualized hydration.
Calculated fluid needs were 1450mls/day.

A review and averaging of the resident's 24hr fluid intake-look back report for month D revealed the following:
Average daily intake in month D = 680mls/day
Average daily intake in month E = 644mls/day
Average daily intake in month F = 326mls/day

Record review identified that on an identified date in month F, the resident had not voided for over 24 hours and a dehydration assessment was completed indicating that the resident was very dehydrated and continued to refuse fluids. A dietary quarterly assessment within month F, revealed that the resident was declining with very poor intake of food and fluids and that dietary staff are to continue to offer the diet as ordered, health care aides to provide assistance as needed and registered staff to continue to monitor overall progress.

Resident was deemed palliative on an identified date within month F, and passed away four days later.

An interview with the DOC confirmed that resident #15's 24hr fluid intake-look back report from residents admission, month A until month F, consistently did not meet his/her minimum fluid requirements. The DOC confirmed that the plan of care had remained unchanged and did not meet his/her needs. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is fully respected and promoted
, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident needs and preferences of that resident.

Record review of resident #11's MDS assessment dated December 24, 2014, revealed that the resident's toileting needs were extensive assistance for toileting. A review of the resident's plan of care indicated he/she was independent in toileting and required direction from staff to find the washroom.

Interviews with an identified PSW and an identified registered staff confirmed resident #11 requires one-person extensive assistance for toileting and staff has to take the resident to the bathroom, adjust the resident's clothes and clean the resident. The identified nursing staff also confirmed that the plan of care is not based on the resident's toileting needs and assessment. [s. 6. (2)]

2. The licensee has failed to ensure that staff and others involved in the different aspects

of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Staff interviews and record review indicated that resident #05 is independent for toileting and required no staff assistance in this area of his/her care. A review of the RAI-MDS assessment for July 19, 2014, indicated that the resident had been assessed as being continent and required no staff assistance for toileting. The RAI-MDS assessment for October 15, and December 31, 2014, indicated that the resident was occasionally incontinent of bladder and required extensive physcial assistance by one staff to toilet. An interview with the RAI-Coordinator confirmed the above information and indicated that the most recent RAI-MDS assessment for the resident were inaccurate and did not demonstrate a collaborative effort around the resident's actual assessed care needs. [s. 6. (4) (a)]

3. Record review identified that resident #15 was deemed palliative on a specified date. Record review further identified that on March 2, 2015, the resident's POA no longer wanted his/her family member to have a specialized diet and requested that resident have something tasty for lunch.
Record review and staff interviews confirmed that registered nursing staff did not communicate to dietary that the resident's status had changed to palliative.
The home's policy Resident Rights, Care and Services-Nutrition Care and Hydration Programs-Nutrition Referral Form Policy, revised date: 11/18/2014 directs nursing staff to send a referral to the food service manager if a resident is palliative.
An interview with the food services manager, revealed that she was made aware of resident's change of status to palliative by her cook on an identified date. The FSM instructed the cook to continue to provide a specialized diet, unaware that the POA had requested the discontinuation of the specialized diet and to provide something tasty to his/her family member.
The food service manager confirmed that she had not spoken to the resident's POA. [s. 6. (4) (a)]

4. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.
Resident #15 was admitted on identified date, with a current weight of 47.4kg and within her average body weight range of 45-55kg.
The admission review assessment by nursing identified that the resident will not drink all fluids offered at meals and nourishment times and will turn his/her head away in refusal

of consumption placing him/her at risk for dehydration. Care plan direction to staff was to focus on staff offering the resident fluids as allowed on his/her defined fluid diet.

The initial RD assessment, identified the resident at high nutritional risk. The resident's approximate fluid intake was assessed at 720mls/day which met 48% of his/her 1500ml fluid goal. Direction provided to staff was to encourage the resident to drink the 1500mls allotment daily.

The initial plan of care, included the following goals related to eating:
To maintain adequate nutrition and individualized hydration.
Calculated fluid needs are 1450mls/day.
To achieve goal weight range.

The total fluids in 24 hours- look back report, revealed that resident #15's average fluid intake was as follows:
Average daily fluid intake in month A, was 522mls/day.
Average daily intake in month B, was 431mls/day.
Average daily intake in month C, was 393mls/day.

Record review revealed that three months later, the quarterly dietary assessment for resident #15's identified resident's approximate fluid intake to be 900mls/day which met 60% of his/her 1500ml fluid goal. Direction was provided to staff to encourage the resident to drink the 1500ml allotment daily. Further record review identified that at the same identified quarterly review assessment, nursing identified that the resident will not drink all fluids offered at meals and nourishment times and will turn his/her head away in refusal of consumption placing him/her at risk for dehydration. Care plan direction to staff was to focus on staff offering the resident fluids as allowed on his/her defined fluid diet.
The total fluids in 24 hours-look back report, revealed that resident #15's average fluid intake was as follows:
Average daily intake in month D = 680mls/day
Average daily intake in month E = 644mls/day
Average daily intake in month F = 326mls/day

In month F, the quarterly review assessment by nursing stated "the resident had very poor fluid intake and refused many fluids when offered. This has caused the resident to be dehydrated and at this time he/she has signs of dehydration, including hypotension and poor skin turgor".

The care plan direction provided to staff was to continue to offer fluids as tolerated to provide symptom relief and palliative care measures due to poor fluid intake as resident is dehydrated.

Resident passed away month G.

An interview with the DOC confirmed that the resident's plan of care related to the resident's goal of meeting his/her fluid requirement of 1450ml had not been effective from the time of resident's admission. The DOC indicated that despite staff awareness of resident's consistently poor fluid intake, that the resident's plan of care had not been revised. [s. 6. (10) (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 care set out in the plan of care is based on an assessment of the resident needs and preferences of that resident., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence

and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Interviews with registered staff indicated that residents who are incontinent are assessed using the home's "assessment for continence" a clinical instrument designed for the assessment of incontinence. The home's Continence Care and Bowel Management-Program policy, dated July 24, 2014, directs registered staff to complete an "assessment for continence" with any decline in bowel and/or bladder continence indicated in completing RAI-MDS.

A review of resident #16's RAI-MDS assessments indicated that on an identified date, the resident was frequently incontinent and required extensive two person physical assistance for toileting. Three months later, the resident was assessed as totally incontinent and required extensive two person physical assistance for toileting. Interviews with both the continence care lead and the RAI-coordinator confirmed that resident #16 had a decline in continence as indicated in the above mentioned RAI-MDS assessments and had not been further assessed by registered staff using the home's "assessment for continence" instrument. [s. 51. (2) (a)]

2. A review of the RAI-MDS assessments over five months indicated that resident #05 had been assessed as being continent and required no staff assistance for toileting. The nest two following RAI-MDS assessments, indicated that the resident was occasionally incontinent of bladder and required extensive assistance to toilet with one staff physical assistance. Interviews with both the staff educator and the RAI-Coordinator confirmed that resident #05 had a decline in continence as indicated in the above mentioned RAI-MDS assessments and had not been further assessed by registered staff using the home's "assessment for continence" instrument. [s. 51. (2) (a)]

3. A review of resident #03's RAI-MDS assessments indicated that on an identified date, the resident was frequently incontinent and required extensive two person physical assistance for toileting. Three months later the resident had been assessed as incontinent and required extensive two person physical assistance for toileting. An Interview with the lead of the continence care program confirmed that resident #03 had a decline in continence as indicated in the above mentioned RAI-MDS assessments and had not been further assessed by registered staff using the home's "assessment for continence" instrument. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

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

Resident #15 was admitted on an identified date, and identified at high nutritional risk. Record review revealed that the resident had an 18 per cent body weight loss within a week. This weight further triggered a 7.5 per cent or greater weight loss over 3 months and a 10 per cent or greater weight loss over 6 months.

Record review further revealed that a month later, resident #15's weight also triggered a greater than 5%, 7.5% and 10% over one month, three months and 6 months respectively,

An interview with the food service manager, who attends the monthly weight exception meetings, identified that resident #15's weight loss during this period had not been identified or assessed by nursing staff or the registered dietitian. The FSM also indicated that a referral from nursing had not been received regarding residents weight loss, as directed by the home's policy Resident Rights, Care and Services-Nutrition Care and Hydration Programs-Monthly Weights and Weight Variance Report. Revised date: 11/04/2014.

Record review and interviews with registered nursing staff and the director of care revealed that nursing had not assessed and documented the significant weight changes experienced by resident #15 between December 2, 2014 and January 1, 2015 as required. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident with the following weight changes is assessed using
an interdisciplinary approach, and that actions are taken and outcomes are evaluated as follows;
a change of 5 per cent of body weight, or more, over one month; a change of 7.5 per cent of body weight, or more, over three months; change of 10 per cent of body weight, or more, over 6 months, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.
On an identified date and home area, lunch meal service was observed. At table X at 12:08p.m., four residents were identified at the table with food and fluids available. One PSW was identified at the table.
Record review and staff interviews revealed that all four residents required total assistance with eating and drinking.
From 12:08p.m. until 12:22 p.m. one PSW assisted one to two residents at the table leaving the other two residents waiting to be assisted with their meal and beverages.
An interview with the PSW and registered staff confirmed that one PSW is assigned to the four residents at table X until a second PSW completes serving soup, entree and dessert to all residents in the dining room. [s. 73. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing was provided to the Residents' Council within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of the meeting minutes of September 5, 2014, October 10, 2014, November 7, 2014, December 5, 2014 and February 6, 2015 the following statement was made.
Request -Residents' Council would like their own bulletin board to display certificates, minutes and other items particular to residents. Request will be made through the administrator.

Interview with the president of Residents' Council and the assistant to Residents' Council confirmed that a written response had not been provide to Resident Council related to the bulletin board request dating back to September 5, 2014. [s. 57. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a process to report and locate residents' lost clothing and personal items.

Resident interviews identified that residents #08 and#02 had reported missing clothing, two and four weeks ago respectively.
Staff interviews on the relevant resident home areas revealed an unawareness of the residents' missing clothing.
Record review for resident #02 and #08 failed to identify any documentation of missing clothing.
An interview with a laundry aide revealed that he/she wasn't aware of resident #08's missing clothing, which resident reported missing two weeks ago. The laundry aide revealed that he/she was aware of resident #02's missing item but was unsure if it was located.
An interview with the ESM confirmed that there is not a process in place to report and locate missing laundry. [s. 89. (1) (a) (iv)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed, of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

Record review revealed that resident #22 fell on an identified date. The resident was sent to the hospital on the same day and was diagnosed with an injury.

Record review of the critical incident report indicated and interview with the DOC confirmed that the above mentioned incident was reported to the Director seven business days after the occurrence of the incident.

Record review revealed that resident #23 fell on an identified date. The resident was sent to the hospital on the same day and was diagnosed with an injury.

Record review of the critical incident report indicated and interview with the DOC confirmed that the above mentioned incident was reported to the Director four business days after the occurrence of the incident. [s. 107. (3) 4.]

Issued on this 22nd day of April, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), GORDANA KRSTEVSKA (600), MATTHEW CHIU (565), VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2015_414110_0002
Log No. / Registre no:	T-1725-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 2, 2015
Licensee / Titulaire de permis :	BARRIE LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	ROBERTA PLACE 503 ESSA ROAD, BARRIE, ON, L4N-9E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CAROLYN MCLEOD

To BARRIE LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how the home will ensure the following areas are addressed:

The hydration program must include the identification of any risks related to hydration and the implementation of interventions to mitigate and manage the risks.

Education to all staff on the home's policy related to identifying risks to hydration and the implementation of interventions to mitigate and manage the risks.

Please submit compliance plan to Diane.Brown@ontario.ca by April 16, 2015

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the hydration program includes the identification of any risks related to hydration as there is no clear direction to

registered staff on monitoring and evaluating fluid intake and when to identify when a resident has not been consuming enough fluids.

Resident #15's plan of care revealed that staff are to monitor intake and output every shift.

Record review revealed that resident #15 required 1500mls fluids per day. The registered dietitian's (RD) initial assessment and care plan in month A, identified that staff were to encourage the resident to drink the 1500ml allotment daily as the resident was presently consuming 50% of 1500ml.
The quarterly review on an identified date, revealed that the resident's approximate fluid intake was 900ml/day which met 60% of his/her 1500ml fluid goal. Staff must offer and encourage the resident to drink the 1500ml allotment daily.
Further record review, revealed that the resident's fluid intake remained poor and less than 1500mls for several months. Resident was hydrated during a routine hospital visit.

A review and averaging of the resident's 24hr fluid intake- look back report revealed the following:

Average daily intake in month A = 522mls/day
Average daily intake in month B = 431mls/day
Average daily intake in month C = 393mls/day
Average daily intake in month D = 680mls/day
Average daily intake in month E = 644mls/day
Average daily intake in month F = 326mls/day

Review of the home' policy titled Nutrition Referral, version #2 dated- November 18, 2014, directs nursing staff to initiate a food service manager/dietitian referral of any concerns with a residents' intake for either food or fluid-especially if it appears to be an ongoing concern or is in anyway abnormal for that resident. Fluid standard used is "less than 75% of goal fluid intake for 3 consecutive days after being on Stop and watch".

Another policy guideline entitled Hydration Referral dated May 23, 2014, indicated that the night health care staff will total all residents intake each day for food and fluid from point of care (POC) and highlight residents who have had less than 50% of their calculated fluid needs for that day and place the

information in the daily planner for next days and evening staff. Registered staff will communicate at morning shift report residents needing to be encouraged to drink more that day; monitor residents for 3 days. The night health care staff will identify when a resident has less than 50% of their calculated fluid needs in a 24 hour period for three consecutive days a referral will be made to the Food service Manager

Record review revealed that there were 39 occurrences of 3 consecutive days resident #15 was not consuming 50% of the daily hydration fluid goal or 53 occurrences of 3 consecutive days for not consuming 75% of the daily hydration fluid goal over a five month period.

Interviews with registered staff indicated that the nursing staff were aware that resident #15 was a poor drinker, but confirmed that they do not evaluate the daily fluid intake of residents.

The food service manager confirmed that from resident's admission and over the following five months, referrals related to decrease fluid intake have not been received.

An interview with the ADOC confirmed that registered nursing staff had not implemented the "stop and watch" component of the policy related to resident #15.

An interview with the DOC confirmed that the resident had not consumed 50% of the daily hydration fluid goal and that dietary referrals had not been sent to the RD. The DOC further indicated that it was the responsibility of the night nurse to print a report of fluid intake consumed for each resident and send a referral to the RD when fluids had been consumed at less than 50% for three consecutive days. The DOC confirmed that night staff had not been reviewing and monitoring residents' fluid intake and that no action had been taken when resident #15's intake was consistently below his/her required fluid needs. [s. 68. (2) (b)] made to the Food service Manager

Record review revealed that there were 39 occurrences of 3 consecutive days resident #15 was not consuming 50% of the daily hydration fluid goal or 53 occurrences of 3 consecutive days for not consuming 75% of the daily hydration fluid goal over a five month period.

Interviews with registered staff indicated that the nursing staff were aware that resident #15 was a poor drinker, but confirmed that they do not evaluate the daily fluid intake of residents.

The food service manager confirmed that from resident's admission and over the following five months, referrals related to decrease fluid intake have not been received.

An interview with the ADOC confirmed that registered nursing staff had not implemented the "stop and watch" component of the policy related to resident #15.

An interview with the DOC confirmed that the resident had not consumed 50% of the daily hydration fluid goal and that dietary referrals had not been sent to the RD. The DOC further indicated that it was the responsibility of the night nurse to print a report of fluid intake consumed for each resident and send a referral to the RD when fluids had been consumed at less than 50% for three consecutive days. The DOC confirmed that night staff had not been reviewing and monitoring residents' fluid intake and that no action had been taken when resident #15's intake was consistently below his/her required fluid needs. [s. 68. (2) (b)] (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 2nd day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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