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

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

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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
Jul 5, 2016	2016_343585_0010	008989-16	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

TELFER PLACE
245 GRAND RIVER STREET NORTH PARIS ON N3L 3V8

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

LEAH CURLE (585), CYNTHIA DITOMASSO (528), YULIYA FEDOTOVA (632)

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): June 13, 14, 15, 2016.

While in the home, four follow-ups were completed to previously issued compliance orders (CO's) during inspection #: 2016_267528_0003. The orders included log # 008989-16 regarding s. 6 (7) plan of care, 008990-16 regarding r. 69 nutrition care and hydration services, 008991-16 regarding r. 72 (3) food production and 008992-16 regarding r. 131 (3) administration of drugs.

During the course of the inspection, the inspector(s) spoke with residents, families, personal support workers (PSW), registered nursing staff, dietary staff, the food service manager (FSM), Registered Dietitian (RD), Assistant Director of Care (ADOC), Director of Care (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Food Quality
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
3 VPC(s)
0 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. 131. (3)	CO #004	2016_267528_0003	528
LTCHA, 2007 s. 6. (7)	CO #001	2016_267528_0003	585
O.Reg 79/10 s. 69.	CO #002	2016_267528_0003	585
O.Reg 79/10 s. 72. (3)	CO #003	2016_267528_0003	585

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #010's plan of care stated they were at high nutrition risk, due but not limited to identified factors. Their plan of care included interventions to receive thickened fluids, a nutritional supplement as well as a dietary intervention added to some food items.

i. Review of the resident's medication administration record (MAR) from May to June 2016 revealed on 15 occasions they did not receive their nutritional supplement. In June 2016, progress notes revealed that staff did not provide it as the fluid consistency was inappropriate. Interview with registered staff #115 confirmed the resident did not receive the supplement as quite often they did not receive the supplement from the kitchen, the supplement provided by the kitchen was not thick enough or they were unable to thicken it on their own to the required consistency. The Food Service Manager (FSM) confirmed the resident was to receive the supplement, product and thickener was in the home as well as dietary staff available in the home to prepare the supplement for the registered staff.

ii. On an identified date in June 2016, the resident was provided with a meal. Interview with dietary staff #116 confirmed the resident's plan of care stated they were to receive an intervention in their food; however it was not provided until the Long-Term Care (LTC) Homes Inspector inquired. The FSM confirmed the resident was to receive the intervention.

iii. On an identified date in June 2016, during a meal observation, the resident was served fluid that was not prepared to the thickness specified in their plan of care. Dietary staff #116 confirmed the fluid contained lumps and a new glass was prepared and served to the resident. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date in June 2016, during a nourishment pass, resident #061 was observed seated in a reclined position with their neck hyper-extended, receiving total assistance with drinking by PSW #117. PSW #117 reported the resident was to be seated upright. Registered staff #113 confirmed the resident was to be upright when eating and drinking to ensure safety. [s. 73. (1) 10.]

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 and ensure that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all fluids were prepared, stored and serviced using methods which preserved taste, nutritive value, appearance and food quality.

Approximately two months prior to the inspection, the home changed to a cornstarch based thickener, thick & easy, for the preparation of all thickened beverages, as reported by dietary staff #100 and confirmed by the FSM.

During the inspection, several observations were made evidencing that thickened fluids were not prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

i. On an identified date in June 2016, PSW #101 reported resident #010 just partially consumed some thickened fluid. PSW #101 reported the fluid which was thicker when they first provided it to the resident; however, confirmed the remaining amount of fluid in the cup poured easily off the spoon.

ii. On an identified date in June 2016, registered staff #119 confirmed a thickened nutritional supplement for resident #010 on their cart was less than care planned consistency. When asked what the home's process was when supplements were not the correct consistency, registered staff #119 reported if the supplement was too thin, they would add a bit of thickener, wait 30 seconds, mix, then determine if more thickener was required in the product. Registered staff #119 proceeded to add an unmeasured amount of thickener to the supplement, which they mixed but it contained clumps. Registered staff #119 then went to the kitchen to obtain a new supplement. The container of thickener on the medication cart stated: "Thickener desired consistency 113/mL, nectar 1.5 teaspoon (tsp), honey 1-2 tablespoon (tbsp), pudding 2-3 tbsp" but did not state how to stir or how long the beverage needed to sit before consumption.

iii. On an identified date in June 2016, PSW #104 stated that thickened nutrition

supplement provided to resident #015 was not the ordered consistency and they requested registered staff #112 add more thickener to the supplement. An unidentified amount of thickener was added to the resident's supplement.

iv. On an identified date in June 2016, during a meal observation, resident #060 was observed with an unconsumed glass of thickened beverage in front of them. Registered staff #112 removed the glass and proceeded to liquid dietary intervention to the supplement. Registered staff #112 was then observed adding four unlevel plastic spoonfuls of thickener to the beverage, as they reported the liquid intervention reduced the viscosity of the beverage. No directions for thickening fluids was located on their medication cart. Registered staff #112 reported they had not received direction from the home regarding the amount of thickener to add to the thickened beverage when adding the liquid intervention, which was confirmed by the FSM.

v. On an identified date in June 2016, during a meal observation, resident #010 was served fluid that was less than the ordered consistency and contained lumps. Dietary staff #116 confirmed the fluid contained lumps, as well as the pitcher of the same thickened beverage in the fridge.

vi. On an identified date in June 2016, during a meal observation, resident #062 was provided a beverage that they did not consume, however it appeared thinner than what they were to receive, as confirmed by dietary staff #100 and PSW #118.

vii. On an identified date in June 2016, during a meal observation, fluid labelled honey thick was observed on the beverage cart in a dining room. The RD confirmed the fluid was a slightly less than honey thick consistency and contained lumps. The FSM confirmed fluid should not be lumpy and the home's expectation was that fluids appearing to be an inappropriate consistency were to be sent back to the kitchen.

viii. Dietary staff #100 stated when preparing beverages, the home followed the thick & easy suggested usage guide; however, reported results varied depending on the type of beverage or water used. The usage guide stated to always measure beverages and thickener using an accurate level measuring spoon and measuring cups/jugs. Always ensure thickened fluids are prepared to meet the specific standards of the individual health care food service department. [s. 72. (3) (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 and ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

As part of the nutrition care and hydration program, the home's process for monitoring weights, effective April 7, 2016, included instructions posted in the spa room to immediately re-weigh a resident with a nurse present if their weight was found to be 2.0 kilograms (kg) higher or lower than the previous month and to mark down the weight on the weight sheet as "CONFIRMED".

Resident #011's plan of care identified they were at moderate nutritional risk due to identified factors.

In early May 2016, the resident's weight record indicated they experienced a significant weight change of greater than five per cent over one month. At the end of May 2016, the Registered Dietitian (RD) documented a request for nursing to re-weigh the resident to ensure accuracy of the measurement. At the beginning of June 2016, the RD completed an assessment of the resident's significant weight change using the measurement from early May 2016.

Review of the home's weight sheet from May 2016, did not indicate the resident's weight from the beginning of May 2016, was confirmed; nor was a re-weigh documented after it was requested by the RD in later May 2016. Interview with the Director of Care (DOC) reported they followed the process to re-weigh the resident and they confirmed the resident's weight change in early May 2016; however, did not document "confirmed" on the weight sheet. [s. 30. (2)]

Issued on this 12th day of July, 2016

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

Original report signed by the inspector.