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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 1, 2018	2017_532590_0019	008406-17	Resident Quality Inspection

Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

St. Andrew's Terrace Long Term Care Community
255 St. Andrew's Street CAMBRIDGE ON N1S 1P1

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

ALICIA MARLATT (590), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 18 - 22, 26 & 27, 2017.

The following intakes were inspected concurrently within this RQI:

Complaint inspection: Log #010360-17/IL-51036-LO was related to falls prevention and management and prevention of abuse and neglect;
Complaint inspection: Log #019107-17/IL-52425-LO was related to medication management and continence care and bowel management;

Follow up inspection: Log #008658-17 was completed for compliance order #001 from a Resident Quality Inspection #2016_271532_0017 and was related to prevention of abuse and neglect;
Follow up inspection: Log #008657-17 was completed for compliance order #002 from a Resident Quality Inspection #2016_271532_0017 and was related to continence care and bowel management;
Critical Incident System (CIS) inspection: Log #007953-17/CIS #2926-000005-17 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care (MRC), the Environmental Services Manager, a Rehab Coordinator, a Resident Assessment Instrument (RAI) Coordinator, a Registered Dietitian (RD), one Registered Nurse (RN), eight Registered Practical Nurses (RPN), 14 Personal Support Workers (PSW), one Dietary Aide, one Housekeeper, a representative of the Residents' Council, a representative of the Family Council, four family members and nine residents.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, Infoline reports, Critical Incident System reports, Family Council meeting minutes, Residents' Council meeting minutes, Professional Advisory Committee (PAC) meeting minutes, Medication Management process reviews, email correspondence, Risk Management reports and policies and procedures relevant to inspection topics.

During the course of the inspection, the inspector(s) observed dining and snack services, recreational activities, infection prevention and control practices, the provision of resident care including resident specific routines, staff and resident interactions, medication administration practices, medication storage areas, all resident home areas, the general maintenance and cleanliness of the home and the posting of required information.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

7 WN(s)
3 VPC(s)
3 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. 19. (1)	CO #001	2016_271532_0017	563
O.Reg 79/10 s. 51. (2)	CO #002	2016_271532_0017	590

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 has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During stage one of the Resident Quality Inspection, an identified resident was identified as being underweight.

Review of the current plan of care for this resident showed that, nursing was to provide a specific amount of a nutritional intervention at identified times during the day. The care plan also documented that if meals were refused extra snacks/nourishment's and nutritional interventions were to be provided if less than 50 percent of the meal was eaten.

The PSW kardex in Point of Care (POC) for this resident did not list any interventions that directed the PSWs to provide extra snacks if less than 50 percent of the resident's meal was consumed.

On a specified date, observations of an identified home care area dining room occurred during a specific meal. The identified resident did not consume the food or fluids offered at lunch. POC documentation for the "1300 Meals" noted 25 percent of the meal was eaten for that meal. There was no documented evidence in POC that the resident received extra snacks/nourishment's or nutritional interventions for that meal.

On a specified date, observations of the resident in the identified home care area dining room occurred during a specific meal. The resident did not take any more than a few bites of the meal and a few sips of fluid. POC documentation for the "1300 Meals" noted 25 percent of the meal was eaten. There was no documented evidence in POC that the resident had received extra snacks/nourishment's or nutritional interventions for that meal.

S&R Nursing Homes Limited FSM 10–19 Oral Supplements policy, last revised on August 9, 2017, stated that if a resident consumed less than 50 percent of a meal, a Registered Team Member, may provide nutritional supplement as a meal replacement, however this must be documented in the resident's progress notes.

There was no documented evidence in the progress notes that the resident received nutritional interventions as a meal replacement on that specific date.

On a specified date, a PSW shared that this resident would be offered food or fluid after a meal at the next scheduled snack time. The PSW shared that the resident did not eat well and acknowledged that an extra snack or nourishment had not been recently offered to the resident when they had not eaten more than 50 percent of their meal. The PSW

explained that the extra snack would be charted in POC under as needed snack or as needed fluid. The intervention “if meals refused, provide extra snacks/nourishment's and nutritional supplements if less than 50% of meal was consumed” was read to the PSW and the PSW verified that the intervention was not clear as to what to provide as a snack.

On September 27, 2017, MRC acknowledged that this resident did not receive extra snacks/nourishment's and nutritional interventions when less than 50 percent of their meal was consumed on the identified dates. The MRC explained that the extra snack or nutritional intervention should be documented in POC. The MRC also agreed that the intervention was vague and did not provide clear direction to the staff who provided the extra snack or nourishment to the resident.

The licensee has failed to ensure that there was a written plan of care for this resident that set out clear directions to staff and others who provided direct care related to extra snacks/nourishment's and nutritional interventions when less than 50 percent of their meal was consumed. [s. 6. (1) (c)]

2. 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.

During stage one of the Resident Quality Inspection, during a staff interview, a specific resident was identified as being underweight and was not receiving nutritional interventions.

Review of this resident's current care plan related to nutrition, showed several nutritional interventions.

Review of this resident's Food and Fluid at Meals records for a 15 day time period in a specific month was completed and showed that this resident ate less than half their meals 40 out of 45 times.

Review of this resident's electronic Medication Administration Records (eMAR) for three identified months in 2017, all showed two separate areas for nutritional documentation. One area was for the regularly scheduled nutritional interventions and was documented each scheduled administration time as given. The other area was for the as needed nutritional interventions if the resident ate less than 50 percent of their meal and showed no documentation in this area during the identified months in 2017 to support that the

nutritional intervention had been given.

Review of this resident's physician orders showed that an order was written to provide the resident with a nutritional intervention if they consumed less than 50 percent of their meal.

S&R Nursing Homes Limited FSM 10–19 Oral Supplements policy, last revised on August 9, 2017, stated that if a resident consumed less than 50 percent of a meal, a Registered Team Member, may provide a supplement as a meal replacement, however this must be documented in the resident's progress notes. The policy identified the brand and amount of supplement to give.

In an interview with a RPN, they shared that they understood the order directed them to provide nutrition and to provide an extra nutritional intervention at meal time if the resident eats less than half their meal. This RPN also shared that staff were to be supervising the resident while they took their nutrition to know how much they took and to document accurate intake. This RPN further shared that this resident usually did not eat well and often refused their meals.

In an interview with the home's Registered Dietitian (RD), the inspector and the RD reviewed the physician's orders, eMAR's and intake records for this resident. The RD had interpreted the order that staff were to give the regularly scheduled nutrition and an extra nutrition at meals if the resident ate less than 50 percent of their meal. They concurred that the care was not provided as outlined in the plan of care.

In an interview with the MRC, they shared that they also interpreted the order the same as the RD and agreed that there may be some confusion with the order and the policy, as the policy did not specifically direct staff to complete this task. They did agree that care was not being provided as outlined in the plan of care.

The licensee has failed to ensure that this resident was offered a nutritional intervention after refusing to eat half their meal as outlined in their plan of care.

The severity of this non-compliance was determined to be a level two as there was potential for actual harm. The scope of this non-compliance was identified as pattern during the course of the inspection. There was a compliance history of this area of legislation being issued in the home on December 3, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection (RQI) #2015_258519_0036. [s. 6. (7)]

Additional Required Actions:

CO # - 002, 003 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. 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

An anonymous complaint was reported to the Ministry of Health and Long-Term Care (MOHLTC). The caller reported that the residents on an identified home care area, were not being fed on time.

On a specific date, observations of the identified home care area dining room occurred during a specific meal. A specific resident was served soup with no assistance for 12 minutes. Water and juice were delivered to the resident in tall clear plastic drinking glasses and then a hot beverage was served in a blue plastic mug. No one attempted to assist the resident with the intake of fluids until 30 minutes after the fluids were delivered. The resident was seated one foot away from the edge of the table, the soup and beverages were not within reach and the adaptive devices were not provided for the soup and fluids. The resident did not consume the food or fluids offered at lunch.

On a specific date, observations of the resident in the identified home care area dining room occurred during a specific meal. The following was observed over a 45 minute time

period when the resident had food placed in front of them: The resident was awake and ready to eat at the start of the meal with beverages placed in front of them in regular glasses. A hot beverage with no lid was placed out of reach in front of the resident. The resident was observed to attempt to load their utensil and feed themselves on several occasions with no assistance and was not successful. The resident then fell asleep and their spoon fell from their hand onto their lap. Two PSW's were observed to view the table this resident was seated at on separate occasions, and neither staff members offered assistance to the resident. The resident was then approached by a PSW and inappropriately attempted to assist with feeding while crouched and the resident was sleeping during this attempt. The PSW was observed to have gotten a new spoon and attempted to wake and feed the resident. The resident did not eat anything else and the meal was removed from the table.

The most recent "Nutrition & Hydration Risk Assessment" in Point Click Care (PCC) stated the resident's assessed level of risk was high related to poor food and fluid intake and significant weight loss.

Review of the current plan of care for this resident stated that physical assistance was required for eating. The eating goal for the resident was to maintain adequate nutrition with assistance. There were two restorative adaptive devices that the resident required for safe and independent intake of hot food and fluids.

On a specific date, a PSW shared that soup was offered to the resident at the beginning of the meal in a specific bowl. The PSW stated that they had never seen the resident use an adaptive device for soup or fluids and further shared, that the resident has had a recent decline and required total assistance at meals more often.

On a specific date, a Dietary Aide (DA), overheard the conversation regarding the adaptive devices for soup and beverages, approached Inspector #563 and explained that the resident did better with the specified bowl. The DA explained that the resident would feed themselves at times, but required more assistance now and acknowledged that the soup and beverages were not offered in the required adaptive devices and should have been.

The “Nutrition Referral" progress note completed in PCC on a specified date, documented that the resident's Power Of Attorney (POA) was requesting adaptive devices.

The “Food Services-Note” in PCC created by the dietitian on a specified date, documented that the resident's condition had declined and there was variable intake of food and fluids requiring total assistance at meals. The note also documented that the POA requested adaptive devices and that the devices would be initiated for meals and snacks.

The “Food Services-Note” in PCC created by the dietitian on a specified date, documented that the resident's condition was declining and was consuming less than half their meals. The note also documented that adaptive devices were in place to encourage fluid intake and that staff were to offer foods and fluids when the resident was receptive.

Record review of the S&R Nursing Homes Ltd. LE 05-11-01 Assistive Devices for Nutrition policy, last revised October 20, 2016, stated the RTM (registered team member) would complete the Resident Meal Observation Assessment if there was a change in the resident's eating ability. A referral would be then sent to the Life Enrichment (LE) department for further follow up regarding the need for adaptive aids. LE would then complete the Adaptive Aids Assessment in PCC during a lunch or dinner meal to determine if a resident would benefit from the use of adaptive aids.

On September 27, 2017, the Manager of Resident Care (MRC) acknowledged that the use of an adaptive aide was included as part of the resident’s plan of care, but that a Resident Meal Observation Assessment and the Adaptive Aids Assessment was not completed.

S&R Nursing Homes Ltd. RCM 11-14 Dining Program policy, last revised on August 7, 2017, stated the following:
- "Each resident will receive encouragement, supervision, and assistance of food and fluid intake to promote his/her safety, comfort, and independence in eating."
- "All residents are to be monitored by nursing team members during meal service."
- "Assist resident to a comfortable position."
- "Their meal will be served when the nursing team member is available to provide assistance."

Record review of the S&R Nursing Homes Ltd. FSM 09-03 Meal Service policy last revised August 9, 2017, stated, "Nursing team members will sit in dining room chairs or adjustable height feeding stools to assist residents with eating. Team members must ensure they are at eye levels when feeding residents to ensure safe feeding techniques."

The licensee has failed to ensure that this resident was provided the appropriate adaptive devices for soup or fluids. The personal assistance and encouragement required at meals was not offered to safely eat and drink as comfortably and independently as possible. The resident was awake and alert at the beginning of the meal and struggled to load the spoon with food. The resident then fell asleep, staff approached the table twice without offering the assistance required and the resident eventually refused the meal and fluids. [s. 73. (1) 9.]

2. During a dining observation, a specific resident was observed to be seated at a table. The resident appeared restless, and would not sit still in their chair; however did remain seated during the meal.

When Inspector #590 arrived to the dining room on the identified home care area on a specific date, to complete an observation of a specific meal, there were already beverages placed in front of the resident that appeared to have not yet been touched as they were still full. A plate of food was placed in front of the resident and the resident did not immediately begin to eat and remained restless in their chair, looking around the dining room. It was not until nine minutes after the plate was placed in front of the resident, that the resident took their first bite. Upon further observation, the resident was able to feed themselves with no difficulty. During the time the plate was placed in front of the resident and the resident's first bite, several PSW's were observed to walk by the resident and did not acknowledge the resident, nor did they provide encouragement to the resident to eat.

Review of this resident's current care plan related to nutrition showed that the resident needed to be cued during meal times and encouraged to eat. The resident required one person physical assistance to provide specific interventions during meals.

Review of the most recent Minimum Data Set (MDS) assessment, showed that the resident required supervision from one person for eating. The resident's Resident Assessment Protocol (RAP) stated that staff were to encourage food and fluid consumption when the resident was receptive.

In an interview with a RPN, they shared that the resident normally required encouragement and cuing during meals, and did not usually require physical assistance with eating.

Record review of the S&R Nursing Homes Ltd. RCM 11-14 Dining Program policy last

revised August 7, 2017 stated, "Each resident will receive encouragement, supervision, and assistance of food and fluid intake to promote his/her safety, comfort, and independence in eating".

In an interview with the MRC, they stated that they expected staff to assist and encourage any resident that may need assistance or encouragement with their meals and oral intake as outlined by the home's policies.

The licensee has failed to ensure that the resident was provided with the encouragement and cuing required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

3. During an interview with a visitor in a resident's room on a specific date, a resident had asked for a drink. Prior to the resident asking for a drink, inspector #590 observed the resident attempt to reach their bedside table to get a glass of fluid and they were not successful. The resident was sitting beside their bedside table with the glass of fluid on top, however, the resident was too far from the table to reach their glass and did not have the strength to reach the glass. At that time the visitor stopped and assisted the resident with a drink from the glass on their bedside table. The inspector asked the visitor if the resident could eat independently and they shared that the resident could, if they were in reach of their food, and said they usually had to help the resident with a drink while they visited their loved one.

Observation of the resident on a specific date and time, was completed. The resident was sitting in the same spot and again their glass of fluid was too far away for them to reach.

In an interview with a PSW, the inspector and the PSW observed the resident in their room and their seating arrangement compared to the location of their glass of fluid. The PSW agreed that the resident was not receiving the required assistance needed for optimal food and fluid intake. The PSW further stated that the resident can eat and drink on their own, but only if everything is in their reach.

In an interview with a RPN, the inspector and the RPN observed the resident in their room and their seating arrangement compared to the location of their glass of fluid. The RPN agreed that the resident was not receiving the required assistance needed for optimal food and fluid intake. The RPN further stated that the resident can eat and drink on their own, if everything is in their reach. The inspector asked the RPN if they knew

what was in the glass and they smelled the glass and looked at it and stated it was probably a nutritional intervention of some sort. The inspector asked the RPN if they had administered this fluid on their shift and they shared they had not administered that fluid to the resident. The RPN stated it was probably the drink from the previous shift as they had just started working. This RPN, when asked if staff were required to stay with residents during nutrition administration and consumption, stated that registered staff were responsible for administering the nutrition and should be staying with the residents so they can accurately document how much the resident took.

Observation of the resident on a specific date and time, was completed in their room. The same observation occurred, the resident was sitting out of reach of their bedside table and could not reach their full glass of fluids.

In an interview with a RPN in the resident's room, the inspector and the RPN observed this resident and their seating arrangement compared to the location of their glass of fluid. The RPN agreed that the fluid was out of reach. The inspector asked what was in the glass and the RPN smelled the glass and stated it smelled like a nutritional intervention. The inspector asked the RPN if they administered the fluid on their shift and they replied no, it must have been yesterday's nutrition because they would be giving the first nutrition on their shift. The RPN further answered that registered staff who administered nutrition were to ensure the residents consumed their nutrition and were responsible for assisting the resident to drink the nutrition if they required any assistance.

S&R Nursing Homes Ltd. RCM 11-14 Dining Program policy, last revised on August 7, 2017, stated, "Each resident will receive encouragement, supervision, and assistance of food and fluid intake to promote his/her safety, comfort, and independence in eating.".

In an interview with the MRC, they shared that they did not expect staff to stay with every resident for nutrition consumption as some residents were independent with eating and drinking and routinely took their nutrition. The MRC further shared that they expected staff to stay and assist residents with their nutrition if they needed assistance.

The licensee has failed to ensure that the resident was provided with the personal assistance required to safely eat and drink as comfortably and independently as possible.

The severity of this non-compliance was determined to be a level two as there is potential for actual harm. The scope of this non-compliance was identified as a pattern

during the course of the inspection. There was a compliance history of this area of legislation being issued in the home on December 3, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection (RQI) #2015_258519_0036. [s. 73. (1) 9.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to give or refuse consent to any treatment, care or services for which his or her consent was required by law, was fully respected and promoted.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) and

was related to residents rights and medication administration.

In an interview with a specific resident's Substitute Decision-Maker (SDM), they shared that the home gave their family member a medication that they did not consent to.

The identified resident was admitted to the home on a specific date. The resident was not able to make decisions for themselves and had a SDM to assist in making informed decisions for them.

When the resident was admitted to the home, their SDM declined to give consent for the home to administer the identified medication, on the "Consent to Treatment and Care" form. There was also a progress note made that same day, acknowledging that the SDM did not sign the consent needed to administer that specific medication.

A progress note on a specified date several months after admission, documented that the SDM did not want the resident to take the identified medication.

Review of the electronic Medication Administration Record (eMAR) for the reported time frame of administration, showed that the resident was administered the identified medication on two separate occasions in a specific month in 2017.

In an interview with the MRC, they shared that it was the home's expectation that resident and SDM wishes were respected when declining medications. [s. 3. (1) 11. ii.]

2. In stage one during an interview with a specific resident's SDM, they shared that they had not consented to the administration of a specific medication and that the home gave it to the resident anyways.

The resident was experiencing pain and the physician ordered a trial of a low dose of a specific medication to be administered for a specific time frame, then to reassess effectiveness a couple days later.

A progress note written on a specified date, documented that the resident's SDM refused to let the resident take the medication stating that their loved one did not need it.

A progress note written on a later specified date, documented that the SDM had requested the medication to be kept on hold until their conference with the home the next day.

In a progress note written on a later specified date, the physician documented that the resident's Power of Attorney (POA) had refused the use of the medication for pain.

A progress note written on a later specified date, documented that the SDM was concerned with the medication order and that the writer of the note, a nurse, had put the medication to be on hold until informed differently by the SDM.

This resident's eMAR showed that the resident was administered the medication on a specific date, regardless of all the notes made.

In an interview with the MRC they shared that the home's expectations were that resident and SDM wishes were respected regarding medication administration.

The licensee has failed to ensure that the resident's right to give or refuse consent to any treatment, care or services for which his or her consent was required by law, was fully respected and promoted.

The severity of this non-compliance was determined to be a level two as there was potential for actual harm. The scope of this non-compliance was identified as an isolated incident during the course of the inspection. The home has a history of unrelated non-compliance. [s. 3. (1) 11. ii.]

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 give or refuse consent to any treatment, care or services for which his or her consent is required by law, is fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

During stage one of the Resident Quality Inspection, a specific resident was identified as having altered skin integrity.

On September 21, 2017, a Rehab Coordinator (RC) shared that weekly skin and wound assessments were completed in the resident's progress notes. The RC shared that the resident had areas of altered skin integrity. The RC was able to provide onset dates for each of the areas of altered skin integrity.

A progress note written on a specific date, requested a consultation visit related to this resident’s altered skin integrity.

The “Skin/Wound” progress note on a specified date, documented information about one area of skin impairment and the treatment that was being provided.

The “Communication Resident/Family” progress note on a specified date, documented that the resident's POA was informed of the resident's health status and treatment

currently being completed for the resident's altered skin integrity. Staff explained to the POA that the resident’s areas of skin impairment were currently being treated.

The "Skin-Weekly Wound Assessment" was not completed in the progress notes related to one area of altered skin integrity. A “Skin/Wound” progress note on a specified date, documented other areas of skin impairment.

Two "Skin-Weekly Wound Assessment" progress notes written on specified days were completed related to the altered skin integrity on one of the resident's areas. There was no weekly assessment completed on a specific date, for the resident’s other area of altered skin integrity .

On September 21, 2017, a RPN shared that once weekly the registered nursing staff were to complete a skin assessment in PCC using the weekly skin assessment progress note.

On September 21, 2017, a RC acknowledged that a weekly assessment was not completed each week for the altered skin integrity.

The licensee has failed to ensure that when the resident was exhibiting altered skin integrity, a weekly assessment was completed by a member of the registered nursing staff.

The severity of this non-compliance was determined to be a level two as there was potential for actual harm. The scope of this non-compliance was identified as an isolated incident during the course of the inspection. The home has a history of this area of legislation being issued in the home on September 29, 2016, as a Written Notification (WN) in a Resident Quality Inspection (RQI) #2016_271532_0017. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Three medication Incidents from the home's second quarter dated for a specific time frame, were reviewed as part of this RQI.

A) Review of a Medication Incident Report for an incident on a specified date, involving an identified resident, showed that only the RN in the extended class (EC) was notified of this medication incident. Areas to document that the resident, resident's SDM, pharmacy service provider, attending physician, Director of Care, prescriber of the drug and the Medical Director were all empty. Review of this resident’s progress notes for the 14 day time period after the incident, showed no documentation of the medication incident.

B) Review of a Medication Incident Report for an incident on a specified date involving an identified resident, showed that only the resident or their SDM and attending physician were notified of this medication incident; there was no date or time documented as to when these people were notified of the incident. Areas to document that the pharmacy service provider, Director of Care, prescriber of the drug and the Medical Director were notified, were all empty. Review of this resident’s progress notes for the 14 day time period after the incident, showed no documentation of the medication incident.

C) Review of a Medication Incident Report for an incident on a specified date involving an identified resident, showed that only the RN (EC) was notified of this medication incident; there was no date or time documented to reflect when the RN(EC) was notified of the incident. Areas to document that the resident, resident's SDM, pharmacy service provider, attending physician, Director of Care, prescriber of the drug and the Medical Director were notified, were all empty. Review of this resident’s progress notes for the 14 day time period after the incident, showed no documentation of the medication incident.

Classic Care Pharmacy's "Reporting Medication Incidents" policy 7.3, last revised in July 2014, stated:

- "All incidents regardless of origin are communicated to Classic Care Pharmacy by providing a completed medication incident form"
-"Classic Care Pharmacy provides Medication Incident Report forms which can be used by the Home for documenting incidents from all origins if a Home-specific/organization form is unavailable."
- "The instructions to complete the Classic Care Pharmacy Medication Incident Report form are located on the back of the form"
- "The Home investigates the circumstances of the medication incident, completes all necessary documentation and reports findings to the Director of Care or designate,

Medical Director, Prescriber, the Resident's attending physician or RN(EC) (see following pages)".

Instructions on the back of the Medication Incident Report form directed staff to: Complete the top of the form, which included areas to document the home name, the date and time of incident and when it was discovered, the resident's name, and listed who the incident was to be reported to and included resident/POA, Pharmacy Service Provider, Attending Physician, Director of Care, Prescriber, Medical Director, RN (EC).

In an interview with a RPN, they shared that the nurse who made the medication error was responsible for notifying the appropriate people, including the resident, the resident's SDM, physician and the pharmacy. They shared that the medication incident form outlined who is to be contacted after a medication incident and provided areas for dates and times of the notifications to be documented.

In an interview with the MRC, they shared that the home's policy did not specifically direct staff to notify the resident or their SDM, however the instructions for completion of the form were on the back of the form and staff should be completing the document as directed per the pharmacy's medication incident policy. They shared that the resident or their SDM should be made aware of medication incidents according to legislation.

The licensee has failed to ensure that medication incidents were reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were reviewed and analyzed.

In an interview with the MRC, they shared that they reviewed all the medication incidents at their quarterly Professional Advisory Committee (PAC) meetings. They shared that the quarterly evaluation reviewed drug trends and patterns in the home, however individual incidents were not reviewed. Individual incidents were only reviewed according to the origin of the error, for example if it was a nursing incident or pharmacy related incident.

Review of the PAC meeting minutes for the second quarter showed that trends reflective of psychotropic medication use, medications that may contribute to falls or fractures,

analgesics and drug utilization were identified and documented. However, they did not analyze any resident specific medication incidents which occurred in the past quarter.

Review of the home's Supplementary Medication Management Process Review for the months of April, May and June 2017, showed a Quantitative Incident and Adverse Event Analysis that addressed on a monthly basis, pharmacy accuracy rate, number of pharmacy incidents, non-pharmacy accuracy rate, number of non-pharmacy incidents and Provincial Average Accuracy Rate, however did not address resident specific medication incidents.

The MRC agreed that resident specific medication incident analysis did not occur at their quarterly meetings as outlined by the LTCHA.

The licensee has failed to ensure that all medication incidents and adverse drug reactions were reviewed and analyzed. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

In an interview with the MRC, they shared that they reviewed all the medication incidents at their quarterly PAC meetings. They shared that the quarterly evaluation reviewed drug trends and patterns in the home. However individual incidents were not reviewed, only reviewed according to the origin of the error, for example if it was a nursing incident or pharmacy related incident.

Review of the PAC meeting minutes dated July 24, 2017, showed that trends reflective of psychotropic medication use, medications that may contribute to falls or fractures, analgesics and drug utilization were identified and documented. However, they did not analyze resident specific medication incidents which occurred in the past quarter.

Review of the home's Supplementary Medication Management Process Review for the months of April, May and June 2017, showed a Quantitative Incident and Adverse Event Analysis that addressed monthly, pharmacy accuracy rate, number of pharmacy incidents, non-pharmacy accuracy rate, number of non-pharmacy incidents and Provincial Average Accuracy Rate, however did not address resident specific medication incidents.

The MRC agreed that resident specific medication incident analysis did not occur at their quarterly meetings as outlined by the LTCHA.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The severity of this non-compliance was determined to be a level one as there is minimal risk for harm. The scope of this non-compliance was identified as widespread during the course of the inspection. The home has a history of unrelated non-compliance. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, and also to ensure that: all medication incidents and adverse drug reactions are reviewed and analyzed and furthermore, to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 was complied with.

Ontario Regulation 68 (2) (a) related to nutrition care and hydration programs, states, that "Every licensee of a long-term care home shall ensure that the programs include 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."

Ontario Regulation 68 (e) i states, that the program includes "a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter."

Review of a specific resident's recorded weights showed that the resident was not weighed in a specific month in 2017.

The home's policy titled "Weights and Heights", policy number FSM 10-10, last revised on June 30, 2017, stated in the procedure section that:
"Upon admission, re-admission and monthly thereafter each resident's weight will be measured in kilograms and recorded on the resident's computerized chart."

In an interview with the MRC, they shared that home's expectation was that residents were weighed upon re-admission to the home and on a monthly basis and acknowledged that this resident was not weighed in the identified month in 2017.

The licensee has failed to ensure that the home's weight policy was complied with.

The severity of this non-compliance was determined to be a level one as there was minimal risk for harm. The scope of this non-compliance was identified as an isolated incident during the course of this inspection. There was a compliance history of this area of legislation being issued in the home on December 3, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection (RQI) #2015_258519_0036. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Upon observation of a refrigerator storing medications in a medication room on the Elm Trail home care area on September 20, 2017, it was noted that there were injectable vials of an identified medication in the fridge for an unidentified resident. The medication was not in a locked box in the fridge, and the fridge did not have a lock on it. The medication was a controlled substance and requires storage in a double-locked stationary area, in a locked area. A RPN noticed the medication when the inspector was observing the fridge, they moved the medication to another storage area and acknowledged that the medication should have been locked in the fridge. The RPN shared that there were no other residents taking that injectable medication in the building and Elm Trail should be the only home care area that this medication was stored.

The inspector and the RPN went and observed the other fridge that the medication on Elm Trail was moved to. The room was locked and could only be accessed by registered staff and the medication was locked in a box in the fridge, and the fridge was locked. The fridge, however, was able to be moved and was not stationary. The fridge was made

stationary that same afternoon.

On September 21, 2017, the RPN shared that they had located 11 vials of injectable medication in the Cedar Woods home care area medication fridge and had moved them to the new secured fridge. The RPN shared that they wanted to double check for medication after they told the Inspector that there were no other residents taking this medication, just to make sure they were right.

In an interview with the MRC, they acknowledged that the medication should have been double-locked in the medication room and was not, and that the fridge in the exam room should also have been stationary and was not.

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The severity of this non-compliance was determined to be a level one as there was minimal risk for harm. The scope of this non-compliance was identified as a pattern during the course of the inspection. There was a compliance history of this area of legislation being issued in the home on December 3, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection (RQI) #2015_258519_0036. [s. 129. (1) (b)]

Issued on this 6th day of February, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Long-Term Care 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) :	ALICIA MARLATT (590), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2017_532590_0019
Log No. / No de registre :	008406-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 1, 2018
Licensee / Titulaire de permis :	Steeves & Rozema Enterprises Limited 265 North Front Street, Suite 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	St. Andrew's Terrace Long Term Care Community 255 St. Andrew's Street, CAMBRIDGE, ON, N1S-1P1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mark Van Dyke

To Steeves & Rozema Enterprises Limited, 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. 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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that a specified resident, and all residents who require assistive devices for optimal nutritional intake, are provided with the assistive devices identified in their nutritional assessments and plan of care for every meal and snack consumed.

The licensee shall ensure that specified residents, and any resident requiring physical assistance or encouragement by staff to safely eat or drink at meal or snack time, receives the assistance needed as outlined in their plan of care.

The licensee shall ensure that when staff provides a specified resident with food or drink in their room, the staff must ensure that the resident is positioned comfortably with nutrition placed safely within reach allowing resident to consume independently.

The licensee shall ensure that their policies titled "Assistive Devices for Nutrition" and "Dining Program" and "Meal Service" are complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

During a dining observation, a specific resident was observed to be seated at a table. The resident appeared restless, and would not sit still in their chair; however did remain seated during the meal.

When Inspector #590 arrived to the dining room on the identified home care area on a specific date, to complete an observation of a specific meal, there were already beverages placed in front of the resident that appeared to have not yet been touched as they were still full. A plate of food was placed in front of the resident and the resident did not immediately begin to eat and remained restless in their chair, looking around the dining room. It was not until nine minutes after the plate was placed in front of the resident, that the resident took their first bite. Upon further observation, the resident was able to feed themselves with no difficulty. During the time the plate was placed in front of the resident and the resident's first bite, several PSW's were observed to walk by the resident and did not acknowledge the resident, nor did they provide encouragement to the resident to eat.

Review of this resident's current care plan related to nutrition showed that the resident needed to be cued during meal times and encouraged to eat. The resident required one person physical assistance to provide specific interventions during meals.

Review of the most recent Minimum Data Set (MDS) assessment, showed that the resident required supervision from one person for eating. The resident's Resident Assessment Protocol (RAP) stated that staff were to encourage food and fluid consumption when the resident was receptive.

In an interview with a RPN, they shared that the resident normally required encouragement and cuing during meals, and did not usually require physical assistance with eating.

Record review of the S&R Nursing Homes Ltd. RCM 11-14 Dining Program policy last revised August 7, 2017 stated, "Each resident will receive encouragement, supervision, and assistance of food and fluid intake to promote his/her safety, comfort, and independence in eating".

In an interview with the MRC, they stated that they expected staff to assist and encourage any resident that may need assistance or encouragement with their meals and oral intake as outlined by the home's policies.

The licensee has failed to ensure that the resident was provided with the encouragement and cuing required to safely eat and drink as comfortably and independently as possible.
(590)

2. During an interview with a visitor in a resident's room on a specific date, a resident had asked for a drink. Prior to the resident asking for a drink, inspector #590 observed the resident attempt to reach their bedside table to get a glass of fluid and they were not successful. The resident was sitting beside their bedside table with the glass of fluid on top, however, the resident was too far from the table to reach their glass and did not have the strength to reach the glass. At that time the visitor stopped and assisted the resident with a drink from the glass on their bedside table. The inspector asked the visitor if the resident could eat independently and they shared that the resident could, if they were in reach of their food, and said they usually had to help the resident with a drink while they visited their loved one.

Observation of the resident on a specific date and time, was completed. The resident was sitting in the same spot and again their glass of fluid was too far away for them to reach.

In an interview with a PSW, the inspector and the PSW observed the resident in their room and their seating arrangement compared to the location of their glass of fluid. The PSW agreed that the resident was not receiving the required assistance needed for optimal food and fluid intake. The PSW further stated that the resident can eat and drink on their own, but only if everything is in their reach.

In an interview with a RPN, the inspector and the RPN observed the resident in their room and their seating arrangement compared to the location of their glass of fluid. The RPN agreed that the resident was not receiving the required assistance needed for optimal food and fluid intake. The RPN further stated that the resident can eat and drink on their own, if everything is in their reach. The inspector asked the RPN if they knew what was in the glass and they smelled the glass and looked at it and stated it was probably a nutritional intervention of some sort. The inspector asked the RPN if they had administered this fluid on their shift and they shared they had not administered that fluid to the resident. The RPN stated it was probably the drink from the previous shift as they had just started working. This RPN, when asked if staff were required to stay with residents during nutrition administration and consumption, stated that registered staff were responsible for administering the nutrition and should be staying with the residents so they can accurately document how much the resident took.

Observation of the resident on a specific date and time, was completed in their room. The same observation occurred, the resident was sitting out of reach of their bedside table and could not reach their full glass of fluids.

In an interview with a RPN in the resident's room, the inspector and the RPN observed this resident and their seating arrangement compared to the location of their glass of fluid. The RPN agreed that the fluid was out of reach. The inspector asked what was in the glass and the RPN smelled the glass and stated it smelled like a nutritional intervention. The inspector asked the RPN if they administered the fluid on their shift and they replied no, it must have been yesterday's nutrition because they would be giving the first nutrition on their shift. The RPN further answered that registered staff who administered nutrition were

to ensure the residents consumed their nutrition and were responsible for assisting the resident to drink the nutrition if they required any assistance.

S&R Nursing Homes Ltd. RCM 11-14 Dining Program policy, last revised on August 7, 2017, stated, "Each resident will receive encouragement, supervision, and assistance of food and fluid intake to promote his/her safety, comfort, and independence in eating.".

In an interview with the MRC, they shared that they did not expect staff to stay with every resident for nutrition consumption as some residents were independent with eating and drinking and routinely took their nutrition. The MRC further shared that they expected staff to stay and assist residents with their nutrition if they needed assistance.

The licensee has failed to ensure that the resident was provided with the personal assistance required to safely eat and drink as comfortably and independently as possible.
(590)

3. An anonymous complaint was reported to the Ministry of Health and Long-Term Care (MOHLTC). The caller reported that the residents on an identified home care area, were not being fed on time.

On a specific date, observations of the identified home care area dining room occurred during a specific meal. A specific resident was served soup with no assistance for 12 minutes. Water and juice were delivered to the resident in tall clear plastic drinking glasses and then a hot beverage was served in a blue plastic mug. No one attempted to assist the resident with the intake of fluids until 30 minutes after the fluids were delivered. The resident was seated one foot away from the edge of the table, the soup and beverages were not within reach and the adaptive devices were not provided for the soup and fluids. The resident did not consume the food or fluids offered at lunch.

On a specific date, observations of the resident in the identified home care area dining room occurred during a specific meal. The following was observed over a 45 minute time period when the resident had food placed in front of them: The resident was awake and ready to eat at the start of the meal with beverages placed in front of them in regular glasses. A hot beverage with no lid was placed out of reach in front of the resident. The resident was observed to attempt to

load their utensil and feed themselves on several occasions with no assistance and was not successful. The resident then fell asleep and their spoon fell from their hand onto their lap. Two PSW's were observed to view the table this resident was seated at on separate occasions, and neither staff members offered assistance to the resident. The resident was then approached by a PSW and inappropriately attempted to assist with feeding while crouched and the resident was sleeping during this attempt. The PSW was observed to have gotten a new spoon and attempted to wake and feed the resident. The resident did not eat anything else and the meal was removed from the table.

The most recent "Nutrition & Hydration Risk Assessment" in Point Click Care (PCC) stated the resident’s assessed level of risk was high related to poor food and fluid intake and significant weight loss.

Review of the current plan of care for this resident stated that physical assistance was required for eating. The eating goal for the resident was to maintain adequate nutrition with assistance. There were two restorative adaptive devices that the resident required for safe and independent intake of hot food and fluids.

On a specific date, a PSW shared that soup was offered to the resident at the beginning of the meal in a specific bowl. The PSW stated that they had never seen the resident use an adaptive device for soup or fluids and further shared, that the resident has had a recent decline and required total assistance at meals more often.

On a specific date, a Dietary Aide (DA), overheard the conversation regarding the adaptive devices for soup and beverages, approached Inspector #563 and explained that the resident did better with the specified bowl. The DA explained that the resident would feed themselves at times, but required more assistance now and acknowledged that the soup and beverages were not offered in the required adaptive devices and should have been.

The “Nutrition Referral" progress note completed in PCC on a specified date, documented that the resident's Power Of Attorney (POA) was requesting adaptive devices.

The “Food Services-Note” in PCC created by the dietitian on a specified date, documented that the resident's condition had declined and there was variable

intake of food and fluids requiring total assistance at meals. The note also documented that the POA requested adaptive devices and that the devices would be initiated for meals and snacks.

The “Food Services-Note” in PCC created by the dietitian on a specified date, documented that the resident's condition was declining and was consuming less than half their meals. The note also documented that adaptive devices were in place to encourage fluid intake and that staff were to offer foods and fluids when the resident was receptive.

Record review of the S&R Nursing Homes Ltd. LE 05-11-01 Assistive Devices for Nutrition policy, last revised October 20, 2016, stated the RTM (registered team member) would complete the Resident Meal Observation Assessment if there was a change in the resident's eating ability. A referral would be then sent to the Life Enrichment (LE) department for further follow up regarding the need for adaptive aids. LE would then complete the Adaptive Aids Assessment in PCC during a lunch or dinner meal to determine if a resident would benefit from the use of adaptive aids.

On September 27, 2017, the Manager of Resident Care (MRC) acknowledged that the use of an adaptive aide was included as part of the resident’s plan of care, but that a Resident Meal Observation Assessment and the Adaptive Aids Assessment was not completed.

S&R Nursing Homes Ltd. RCM 11-14 Dining Program policy, last revised on August 7, 2017, stated the following:
- "Each resident will receive encouragement, supervision, and assistance of food and fluid intake to promote his/her safety, comfort, and independence in eating."
- "All residents are to be monitored by nursing team members during meal service."
- "Assist resident to a comfortable position."
- "Their meal will be served when the nursing team member is available to provide assistance."

Record review of the S&R Nursing Homes Ltd. FSM 09-03 Meal Service policy last revised August 9, 2017, stated, "Nursing team members will sit in dining room chairs or adjustable height feeding stools to assist residents with eating. Team members must ensure they are at eye levels when feeding residents to ensure safe feeding techniques."

The licensee has failed to ensure that this resident was provided the appropriate adaptive devices for soup or fluids. The personal assistance and encouragement required at meals was not offered to safely eat and drink as comfortably and independently as possible. The resident was awake and alert at the beginning of the meal and struggled to load the spoon with food. The resident then fell asleep, staff approached the table twice without offering the assistance required and the resident eventually refused the meal and fluids.

The severity of this non-compliance was determined to be a level two as there is potential for actual harm. The scope of this non-compliance was identified as a pattern during the course of the inspection. There was a compliance history of this area of legislation being issued in the home on December 3, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection (RQI) #2015_258519_0036.

(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that a specified resident's care plan sets out clear directions to staff and others who provide direct care to the resident related to the extra snack to be provided when the resident eats less than half their meal.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During stage one of the Resident Quality Inspection, an identified resident was identified as being underweight.

Review of the current plan of care for this resident showed that, nursing was to provide a specific amount of a nutritional intervention at identified times during the day. The care plan also documented that if meals were refused extra snacks/nourishment's and nutritional interventions were to be provided if less than 50 percent of the meal was eaten.

The PSW kardex in Point of Care (POC) for this resident did not list any interventions that directed the PSWs to provide extra snacks if less than 50 percent of the resident's meal was consumed.

On a specified date, observations of an identified home care area dining room occurred during a specific meal. The identified resident did not consume the

food or fluids offered at lunch. POC documentation for the "1300 Meals" noted 25 percent of the meal was eaten for that meal. There was no documented evidence in POC that the resident received extra snacks/nourishment's or nutritional interventions for that meal.

On a specified date, observations of the resident in the identified home care area dining room occurred during a specific meal. The resident did not take any more than a few bites of the meal and a few sips of fluid. POC documentation for the "1300 Meals" noted 25 percent of the meal was eaten. There was no documented evidence in POC that the resident had received extra snacks/nourishment's or nutritional interventions for that meal.

S&R Nursing Homes Limited FSM 10–19 Oral Supplements policy, last revised on August 9, 2017, stated that if a resident consumed less than 50 percent of a meal, a Registered Team Member, may provide nutritional supplement as a meal replacement, however this must be documented in the resident's progress notes.

There was no documented evidence in the progress notes that the resident received nutritional interventions as a meal replacement on that specific date.

On a specified date, a PSW shared that this resident would be offered food or fluid after a meal at the next scheduled snack time. The PSW shared that the resident did not eat well and acknowledged that an extra snack or nourishment had not been recently offered to the resident when they had not eaten more than 50 percent of their meal. The PSW explained that the extra snack would be charted in POC under as needed snack or as needed fluid. The intervention “if meals refused, provide extra snacks/nourishment's and nutritional supplements if less than 50% of meal was consumed” was read to the PSW and the PSW verified that the intervention was not clear as to what to provide as a snack.

On September 27, 2017, MRC acknowledged that this resident did not receive extra snacks/nourishment's and nutritional interventions when less than 50 percent of their meal was consumed on the identified dates. The MRC explained that the extra snack or nutritional intervention should be documented in POC. The MRC also agreed that the intervention was vague and did not provide clear direction to the staff who provided the extra snack or nourishment to the resident.

The licensee has failed to ensure that there was a written plan of care for this resident that set out clear directions to staff and others who provided direct care related to extra snacks/nourishment's and nutritional interventions when less than 50 percent of their meal was consumed.

The severity of this non-compliance was determined to be a level two as there was potential for actual harm. The scope of this non-compliance was identified as pattern during the course of the inspection. There was a compliance history of this area of legislation being issued in the home on December 3, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection (RQI) #2015_258519_0036. [s. 6. (7)]
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 the specified resident receives the care related to nutrition as outlined in their plan of care.

The licensee shall ensure that the homes "Oral Supplement" policy is complied with when any resident's oral intake is poor.

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.

During stage one of the Resident Quality Inspection, during a staff interview, a specific resident was identified as being underweight and was not receiving nutritional interventions.

Review of this resident's current care plan related to nutrition, showed several nutritional interventions.

Review of this resident's Food and Fluid at Meals records for a 15 day time period in a specific month was completed and showed that this resident ate less than half their meals 40 out of 45 times.

Review of this resident's electronic Medication Administration Records (eMAR) for three identified months in 2017, all showed two separate areas for nutritional documentation. One area was for the regularly scheduled nutritional interventions and was documented each scheduled administration time as given. The other area was for the as needed nutritional interventions if the resident ate less than 50 percent of their meal and showed no documentation in this area during the identified months in 2017 to support that the nutritional intervention

had been given.

Review of this resident's physician orders showed that an order was written to provide the resident with a nutritional intervention if they consumed less than 50 percent of their meal.

S&R Nursing Homes Limited FSM 10–19 Oral Supplements policy, last revised on August 9, 2017, stated that if a resident consumed less than 50 percent of a meal, a Registered Team Member, may provide a supplement as a meal replacement, however this must be documented in the resident's progress notes. The policy identified the brand and amount of supplement to give.

In an interview with a RPN, they shared that they understood the order directed them to provide nutrition and to provide an extra nutritional intervention at meal time if the resident eats less than half their meal. This RPN also shared that staff were to be supervising the resident while they took their nutrition to know how much they took and to document accurate intake. This RPN further shared that this resident usually did not eat well and often refused their meals.

In an interview with the home's Registered Dietitian (RD), the inspector and the RD reviewed the physician's orders, eMAR's and intake records for this resident. The RD had interpreted the order that staff were to give the regularly scheduled nutrition and an extra nutrition at meals if the resident ate less than 50 percent of their meal. They concurred that the care was not provided as outlined in the plan of care.

In an interview with the MRC, they shared that they also interpreted the order the same as the RD and agreed that there may be some confusion with the order and the policy, as the policy did not specifically direct staff to complete this task. They did agree that care was not being provided as outlined in the plan of care.

The licensee has failed to ensure that this resident was offered a nutritional intervention after refusing to eat half their meal as outlined in their plan of care.

The severity of this non-compliance was determined to be a level two as there was potential for actual harm. The scope of this non-compliance was identified as pattern during the course of the inspection. There was a compliance history of this area of legislation being issued in the home on December 3, 2015, as a

Voluntary Plan of Correction (VPC) in a Resident Quality Inspection (RQI) #2015_258519_0036.
(590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 1st day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alicia Marlatt

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