Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Nov 3, 2017	2017_556168_0030	023073-17	Resident Quality Inspection

Licensee/Titulaire de permis

HALDIMAND WAR MEMORIAL HOSPITAL
206 JOHN STREET DUNNVILLE ON N1A 2P7

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

EDGEWATER GARDENS LONG TERM CARE CENTRE
428 BROAD STREET WEST DUNNVILLE ON N1A 1T3

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

LISA VINK (168), DIANNE BARSEVICH (581), JESSICA PALADINO (586)

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): October 3, 4, 5, 6 and 10, 2017.

During the course of this inspection, the following additional inspections were conducted concurrently:
Complaints
009259-17 - related to multiple care concerns
021871-17 - related to multiple care concerns

Follow Up
009075-17 - related to training.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), registered dietitian (RD), housekeeping staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), dietary staff, recreation supervisor, dietary and environmental services manager (DESM), families and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services and reviewed relevant documents including but not limited to clinical health care records, policies and procedures, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Residents' Council
Training and Orientation

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

14 WN(s)
6 VPC(s)
5 CO(s)
1 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents, as a condition of continued contact with residents, received training in the following areas: how to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations and any other areas provided for in the regulations.

The licensee failed to ensure that all staff who provided direct care to residents, as a condition of continued contact with residents, received training in the following areas: how to minimize the restraining of residents and where restraining was necessary, how to do so in accordance with this Act and the regulations and any other areas provided for in the regulations.

A. In October 2016, the home was served a compliance order to ensure that all direct care staff received training related to the minimizing of restraining in accordance with the Act and regulations. This order was served again during a Follow Up inspection in April 2017, with a compliance date of June 30, 2017.
The Administrator/DOC identified that the required training was completed in the home

by one to one training, small group training and in some cases online training using the Surge Learning Program.
A review of the Staff Sign Off for Restraint Education - February 2017, identified that three percent, or two of sixty-one, direct care staff did not receive the required training on the minimizing of restraining.
Interview with the Administrator/DOC verified that PSW #118 and PSW #119 did not receive the required training, were current employes of the home and were available for work.
On October 6, 2017, interview with PSW #118 identified they could not recall recent training on the minimizing of restraining.
A review of the Surge Course Completion records, for the Minimizing of Restraints and PASD`s, identified that three of the staff, that completed the required training online, completed the training after June 30, 2017. One staff member completed the training on July 24, 2017, another on August 24, 2017 and the third staff member on September 6, 2017.

B. Ontario Regulation 79/10 section 21(2)(2) identifies that "ìf the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs".
In October 2016, the home was served a compliance order to ensure that all staff used safe transferring and positioning techniques when they assisted residents. The licensee was directed to educate all PSW staff on all equipment used for transferring and positioning. This order served again during a Follow Up inspection in April 2017, with a compliance date of June 30, 2017.
A review of the Lift Training Sign Off provided for the required education, identified that eleven percent, or four of thirty-five, PSW staff did not receive the required training on the use of transferring and positioning equipment.
Interview with the Administrator/DOC verified that PSWs #113, #115, #116 and #117 did not receive the required training, were current employes of the home and were available for work.
On October 6, 2017, interviews with PSW staff #113 and #116 verified that they had not recently received training, at the home, on the safe use of equipment and transfers. [s. 76. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

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

Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), the decision to use, continue to use, or to discontinue the use of a bed rail would be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the resident's substitute decision maker (SDM). The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of

passed or failed zones 1-4). Consideration of these factors would more accurately guide the assessor in making a decision, with either the resident or by the resident's SDM about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A. Review of the plan of care for resident #030 identified they had bed rails raised on their bed for safety when admitted to the home in 2017; however, there was no bed rail assessment completed.
On an identified date, the resident's bed was observed with no bed rails in place.
Interview with PSW #107 stated the resident previously had bed rails but that they were removed several months ago.
Interview with the Administrator/DOC indicated that the home removed most of the bed rails off the residents' bed in May 2017 and confirmed that the home did not complete a bed rail assessment when the resident was admitted, nor prior to removing the bed rails.
B. Review of the plan of care identified that resident #044 had bed rails raised when in bed, when admitted to the home in 2017, for safety; however, there was no bed rail assessment completed.
Interview with RN #100 stated the resident previously had bed rails on their bed but that they were removed several months ago.
Interview with the Administrator/DOC confirmed that a bed rail assessment was not completed when the resident was admitted, as the home did not complete bed rail assessments until May 2017. They also confirmed that a bed rail assessment was not completed when the bed rails were removed from the bed to determine if the resident still required the use of the bed rails.
C. According to the clinical record resident #048 requested the use of bed rails, the day following their admission in 2017 and progress notes confirmed the use of the rails.
The SDM was contacted the same day and verbally agreed to the use of the rails and a consent was signed the following day.
The Minimum Data Set (MDS) assessment completed January 2017, identified that other types of bed rails were used - for example half or one side rail, daily.
The MDS assessment and Alternatives to Restraints/PASD (Personal Assistance Services Device) Checklist, both completed in April 2017, noted that the resident did not use rails; however, the Resident Assessment Protocol (RAP) for the same time period identified the use of rails.
Progress notes of May 2017, identified that on an identified date, at 0300 hours, the bed

rails were down and were raised on request.
A note the following day, at 0034 hours, identified that the resident requested to have the bed rails up.
A progress note in July 2017, identified that the resident did not use bed rails in bed.
The MDS assessment completed in July 2017, identified that bed rails were not used.
A review of the clinical record did not include any assessment related to the use of bed rails prior to the initial application or during any of the removals.
Interview with the Administrator/DOC confirmed that bed rail assessment were not completed until May 2017. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: hydration status, and any risks related to hydration.

A. Progress notes by the RD were reviewed from resident #004's admission in 2016,

until June 2017, whereby each quarterly review indicated that the resident was below their daily fluid target.
One progress note, in 2017, identified the resident needed encouragement to drink fluids.

Review of the resident's documented plan of care, which front line staff used to direct care, did not include a hydration section, or any mention of the resident's hydration needs or need for encouragement to consume fluids.
B. On an identified date, the resident was observed in the dining room during the lunch meal.
They had 250 ml water waiting for them along with an empty coffee mug.
PSW #105 arrived with the beverage cart and asked the resident if they wanted a beverage.
The resident was eating their soup and did not answer the staff.
The PSW then asked "Are you sure you don't want any beverage?" to which the resident again did not respond.
The PSW proceeded to leave the resident's table and serve other residents beverages.
The resident did not drink any of their fluids until the RPN administered their medications, at which time they drank one-quarter of their 250 ml glass of water.
The resident was not offered any coffee or tea.

During an interview with PSW #103 they indicated that the resident typically did not respond when staff asked them what they wanted, therefore they often left a beverage on the table for the resident.

In an interview with the RD they confirmed that the resident's plan of care did not include an interdisciplinary assessment of the resident's hydration status or any information about the resident's risks related to hydration, including interventions for staff. [s. 26. (3) 14.]

2. The licensee failed to ensure that the RD, who was a member of the staff of the home, completed a nutritional assessment for residents whenever there was a significant change in the resident's health condition; and assessed the resident's hydration status, and any risks related to hydration.

Progress notes by the RD were reviewed from resident #004's admission in 2016, until June 2017, whereby each quarterly review indicated that the resident was below their daily fluid target.
One progress note, in 2017, identified that the resident needed encouragement to drink

their fluids.
The Nutrition/Hydration Risk Identification Tool completed in September 2017, by the RD, identified that the resident was at a moderate nutritional risk due to poor fluid intake.
The resident's fluid intake records from the Point of Care (POC) documentation program, over one month, were reviewed.
The POC records revealed that the resident was below their target fluid requirement for 22 out of the 32 days, ranging from 125 ml to 1,125 ml per day.

The home's policy, Hydration Management Policy, NC-03-220, last reviewed April 9, 2014, indicated that registered nursing staff would complete and send a dietary department requisition/referral form to the Nutrition and Food Service department when a resident consistently had a poor fluid intake of less than 1,500 cubic centimetres (cc) per day for three days or more. Once a referral was sent, the DESN would refer the resident to the RD to complete an assessment.

In an interview with the RD, on October 5, 2017, they indicated that they were the only person responsible to review and assess resident fluid records, not nursing staff; therefore, they did not receive any poor fluid intake referrals for any residents.
They indicated that they only reassessed a resident's hydration status quarterly and that they were not aware of resident #004's poor fluid intake, having consumed less than their target fluid requirement, and had not received any referrals when the resident consumed less than 1,500 ml per day as per policy. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: hydration status, and any risks related to hydration, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation).

Review of the registered nursing staffing schedule from July 1, 2017, until October 1, 2017, identified that a Registered Nurse (RN) that was a member of the regular nursing staff was not on duty and present at all times, on the following dates:
* On July 6, 2017, from 1500 until 2300 hours, on evening shift;
* On July 11, 2017, from 1500 until 1900 hours of the evening shift;
* On July 23, 2017, from 0700 until 1100 hours on the day shift;
* On August 3, 2017, from 1500 until 1900 hours on the evening shift;
* On August 10, 2017, from 0700 until 1500 hours on the day shift and from 1500 until 1900 hours on the evening shift; and.
* On September 25, 2017, from 1900 until 2300 hours on the evening shift.

Interview with the Administrator/DOC stated there was no RN in the building on the shifts listed above and confirmed that the home was unable to staff those shifts with an RN who was an employee of the home. [s. 8. (3)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. LTCHA, 2007 section 8, identifies that "every licensee of a long-term care home shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of all residents".

The home had a procedure Diabetes: Hypoglycemia/Insulin Reaction, N-19-11, dated January 31, 2016.
This procedure included a process flow for staff to follow when a resident demonstrated signs and symptoms of hypoglycemia.
This process flow identified that if a resident's capillary blood sugar (CBG) was low (less than three) staff were to take the following action:
A. If the resident was conscious and cooperative give three ounces (oz) orange juice with one tablespoon (tbsp) sugar, follow with half (1/2) a piece of bread or cookie and a glass of milk. Staff were then to monitor the resident for five to ten minutes. If the resident's condition remained unchanged then recheck the CBG and if the results of the test was greater than the last CBG, give a glass of milk and a sandwich, monitor for another five to ten minutes and recheck CBG and add to next Doctor's Day.
B. If the resident was conscious and resistive/uncooperative give glucagon, monitor, recheck CBG, repeat glucagon if not improved, recheck CBG, notify doctor if not improving, if resident conscious, repeat CBG.

An identified resident had a diagnosis and a physician's order for insulin.
A review of the CBG records and progress notes identified that the resident had episodes of hypoglycemia over a four day period of time in 2017.

A review of the clinical records identified that on each occasion of hypoglycemia staff did not consistently follow all of the actions as identified in the procedure. Interview with RPN #126, who worked during one of the incidents was shown a copy of the procedure Diabetes: Hypoglycemia/Insulin Reaction, N-19-11, dated January 31, 2016, and identified that she was not familiar with the document.
Interview with RN #112 who responded to another incident confirmed that the procedure Diabetes: Hypoglycemia/Insulin Reaction, N-19-11, dated January 31, 2016, was not readily available for staff, was not posted in the first floor medication room, and that they did not consistently follow the process flow during the incident.
Documentation of two additional incidents of hypoglycemia, were reviewed with the Administrator/DOC.
Following a review of the records the Administrator/DOC verified that the procedure was not consistently followed as required.
The Administrator/DOC revealed that the home had just recently requested the Nurse Practitioner to review the policy to ensure that it provided clear direction and was consistent with prevailing practices.
The Administrator/DOC confirmed that staff did not consistently follow the policy in the examples identified above and identified some areas where they would like to see the policy strengthened.

B. Ontario Regulation 79/10, section 114 identifies that "the licensee shall have written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home".

The home had a procedure Medication Administration, N-24-20, dated March 12, 2010, which identified that during the administration of medication staff were to "remain with the resident until it is swallowed".

On an identified date a portion of a medication pass was observed.
i. Resident #041 was observed to have their medication prepared according to the electronic Medication Administration Record (eMAR) by RN #100.
The RN placed the prepared medication in the resident's room, in the presence of the resident and informed the resident that the medication was present prior to leaving the room.
The RN did not observe the resident take or swallow the medication.
The RN identified that the resident was alert, was able to take the medications and that there was no specific order from the physician for the medications to be self

administered.
ii. Resident #004 was observed in the dining room with a medicine cup, which contained tablets, in front of them at 1310 hours, with no staff in direct attendance.
RN #100 was identified to be in the servery of the dining area.
Inspector #586 identified that they observed RN #100 place the medication cup in front of resident #004 at approximately 1245 hours, prior to leaving the area.
At 1316 hours, the RN returned to the resident, spoke with them, placed the medications on a spoon and administered them to the resident.

On an identified date, at 1148 hours, resident #049 was heard in a discussion with RN #100 regarding medications.
The resident identified that they did not recall taking a medication this morning and directed the RN to go to their room and look for them, if they were still in their room, just to place them in the bedside table drawer for later.
The RN immediately visited the resident's room and returned to the nursing station with a pill cup, which she confirmed contained medications.
When questioned the RN confirmed that the medications were found in the resident`s room and removed.
The RN informed the resident that the medications were removed from their room prior to taking them into the medication room.

Interview with the Administrator/DOC identified that the home had a number of residents who were able to administer their own medications; however, at this time they did not have orders in place to support this activity.

C. Ontario Regulation 79/10, section 68, requires "an organized program of nutrition care and dietary services, including the development and implementation of policies and procedures".

i. The home had a policy, Resident Weights, NC-03-140, last revised January 12, 2011. This policy identified PSW's were to weigh each resident by the fifth of the month and submit the weights to the DESN. The weights would be reviewed by the RD and inputted into Point Click Care (PCC), and any weight difference of 2.5 kilograms (kg) from the previous months' weight would require a re-weigh, so a Monthly Weight Assessment Tool would be initiated and returned to the units to be completed within 24 hours and returned to the DESN/RD.

Resident #005's plan of care indicated that they were at a high nutritional risk due to a

history of significant weight change and other concerns. The resident experienced a significant weight change, a decrease, over a one month period of time. The RD identified the weight loss and completed the re-weigh tool for staff to complete. Review of the tool and interview with the RD, identified that approximately one week later the re-weigh had still not yet been completed by staff.
Resident #005 did not receive a re-weigh according to the home's policy.

ii. The home had a policy, Nutrition & Hydration Monitoring Form for Meals & Snacks, NC-03-230, last revised April 9, 2014. This policy directed staff to monitor and document the fluid intake of all residents to ensure adequate nutrition and hydration. An additional policy, Clinical Records, N-4-10, directed staff to ensure documentation in resident health records was complete and accurate.

Resident #004 was observed during lunch meal service in the dining room on an identified date. During the meal, the resident ate 180 ml soup and drank one-quarter of a 250 ml glass of water.
The following day, the resident's intake record from POC was reviewed, which identified that they had consumed 600 ml of fluids at lunch as documented by PSW #103.
In an interview with the PSW the following day they indicated that they had a very busy shift; therefore, had to document after the service and recorded "roughly what [they] usually consume[d]".

Progress notes written by the RD in 2017, indicated for resident #003 that over half of the meals over a one week period of time had no food/fluid documentation, therefore it was difficult to assess average fluid intake, and resident #004's chart identified it was difficult to assess fluid intake due approximately one third of the meals were not documented over a one week period of time.
On October 5, 2017, the RD reviewed resident #004's fluid intake record which identified multiple blank entries or incomplete entries in POC, thereby affecting the fluid totals for the day.
The RD, acknowledged that accurate and complete documentation was needed to ensure appropriate assessment of the resident's intake and risks related to hydration and that the polices were not being followed. [s. 8. (1)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Interview with the Administrator/DOC identified that residents were shaved, based on

their preference, some daily others less frequently.
Interview with resident #044 and their SDM identified the preference to receive specific personal hygiene daily, which was known by PSWs #107 and #117 as well as the Administrator/DOC when interviewed.
A review of the plan of care, under the focus statement of personal hygiene, identified the goal for the resident "to express desire to be clean shaven/hair combed" and the intervention to "provide total care to comb hair, shave".
The plan did not provide direction as the the frequency that the care was to be provided.
Interview with the Administrator/DOC verified that the POC records did not provide a "prompt" to direct staff to provide the specific care daily to the resident, their known preference.
Interview with the SDM identified that in their opinion the resident was not consistently provided the care, as was their preference. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. According to the clinical record resident #048 requested the use of bed rails, while in bed to assist in turning and repositioning, the day following their admission in 2017 and progress notes confirmed the use of the rails.
The MDS assessment and Alternatives to Restraints/PASD Checklist, both completed in April 2017, noted that the resident did not use rails; however the RAP for the same time period identified the use of rails.
Interview with RN #112, following a review of the clinical record, confirmed that the assessments were not consistent and did not complement each other.
B. According to the clinical record resident #048 experienced pain and was ordered a medication.
The MDS assessment completed in July 2017, identified that the resident experienced pain daily at a moderate level.
The Pain assessment completed two days prior, identified that the resident experienced pain less than daily and was at a mild level.
Interview with RN #112, following a review of the clinical record, confirmed that the assessments were not consistent with each other; however, they should have been as they were completed with the same clinical information.
C. Review of the MDS admission assessment in 2017, identified that resident #006 was frequently incontinent of bladder.
In July 2017, the MDS assessment indicated they were occasionally incontinent of

bladder.
Interview with RN #112 stated there was an improvement in their urinary continence between quarterly assessments as identified in POC; however, was coded as no change and confirmed the assessments were not consistent with each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A. Review of the plan of care identified that resident #044 had bed rails on the bed when they were admitted in 2017. Interview with RN #100 stated the resident did have bed rails on their bed; however, they were removed several months ago. Interview with the Administrator/DOC stated the home removed the bed rails in May 2017 as the resident was not identified by the PSW staff to use the rails.
The Administrator/DOC confirmed that the SDM was not notified prior to the removal of the bed rails and were not provided an opportunity to participate fully in the development and implementation of the plan of care.
B. Review of the plan of care identified that resident #030 had bed rails on the bed when they were admitted in 2017. Interview with PSW #107 stated the resident did have bed rails on their bed, but they were removed several months ago when the home removed most of the bed rails in the home.
Interview with the Administrator/DOC stated the home removed the bed rails in May 2017 , as the resident was not identified by the PSW staff to require the rails.
The Administrator/DOC confirmed that the SDM was not notified prior to the removal of the bed rails and were not provided an opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

4. The licensee failed to ensure the care was provided to each resident as specified in the plan of care.

A. Progress notes written by the RD identified that resident #004 did not meet their target fluid requirement on average over a three month period of time, as well as 22 out of 32 days on an other occasion in 2017.
The resident's documented plan of care included the use of an aide when needed, which was consistent with the Restorative Aids List kept in the dining room servery.
In an interview the RD confirmed it was the expectation of the dietary aides to set up the dining room with all aides according to the list and that resident #004 should receive the aide at each meal in case they needed to use it. Observation of the resident during

lunch on two dates, identified that they were not provided with the aide and they only consumed one-quarter of their 250 ml water on one day and no water on the second day.

The resident was provided with the aide at supper on the second day and they drank the full serving of milk and coffee from the aide.
The RD acknowledged that the resident was not provided with the care as specified in the plan of care on the identified days during the lunch meals.
B. Resident #045's plan of care indicated that they required altered texture fluids due to a diagnosis which was also posted in the dining room for staff reference.
During the supper meal service on an identified date, PSW #121 was observed to add three scoops of a product to the resident's beverage, stirred, then allowed the drink to sit.

The directions on the product read that one scoop was to be added to 125 ml of fluid to obtain the desired texture.
In an interview with the PSW, they indicated that they were not aware of the texture resident #045 required; however, they added three scoops because that was what other staff did.
Interview with the DESN confirmed that adding three scoops of the product to the beverage would not create the desired texture for the resident, as specified in their plan. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

A. Review of the plan of care for resident #006 identified that they wore a specific continence care product.
Interview with PSW #107 stated the resident used to wear the specific product but now wore a different product on all three shifts.
Review of the Resident Profile Worksheet dated September 13, 2017, indicated the resident wore the different product on all three shifts. Interview with RPN #108 stated that the resident no longer wore the specific continence product and confirmed that the written plan of care was not reviewed and revised when the resident's care needs changed.
B. Review of the current plan of care for resident #044 identified they required bed rails raised when in bed for safety.
The resident's bed was observed with no bed rails on their bed.
Interview and review of the plan of care with RN #100 stated that the resident's bed rails were removed off the bed several months ago and confirmed that the plan of care was

not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, and that the resident, the SDM, if any, and the designate of the resident/SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care, and the care is provided to each resident as specified in the plan of care, and to ensure that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received fingernail care, including the cutting of fingernails.

Resident #044 required staff to complete all aspects of nail care.
The resident was observed on three days and was identified with fingernails with white extending tips, some of which were rough and jagged on the edges.
Interview with PSW #107 and the Administrator/DOC verified the expectation that nail care was be completed on bath days and that the nails, when observed, were long and jagged following an observation of the resident.
The resident, according to the bathing schedule, was to be showered two times a week.
Discussion with the SDM identified, their opinion, that the resident's nails were not maintained clean and short which may have resulted in the resident scratching and causing trauma to their skin. [s. 35. (2)]

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 each resident of the home receives fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met when a resident was being restrained by a physical device under section 31 of the Act: that the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

A. Resident # 001 was observed positioned in a chair with a device applied.
Review of the plan of care identified they required the device as a restraint.
Review of the eMAR from July 1, 2017, until October 3, 2017, identified that the resident was not reassessed by the registered nursing staff on the following shifts/times:
* October 3, 2017, night shift at 0600 hours;
* September 5 and 9, 2017, day shifts at 1400 hours;
* September 12, 14 and 19, 2017, evening shifts at 2200 hours;
* August 2, 2017, night shift at 0600 hours;
* August 2, 4, 16, 22, 27,and 29, 2017, day shifts at 1400 hours;
* August 6, 31, 2017, evening shift at 2200 hours;
* July 2 and 28, 2017, day shifts at 1400 hours.

B. Resident #002 was observed seated in a chair with a device applied.
Review of the plan of care identified they required the device a restraint.
Review of the electronic Treatment Administration Record (eTAR) from July 1, 2017, until October 3, 2017, indicated they were not reassessed by the registered nursing staff on the following shifts/times:
* October 3, 2017, night shift at 0600 hours;
* October 1, 2017, evening shift at 2200 hours;
* September 1, 3, 4 and 14, 2017, night shifts at 0600 hours;
* September 3, 9, 11, and 20, 2017, day shifts at 1400 hours;
* September 4, 11, 13, 14, 15, 16, 17, 18 and 19, 2017, evening shifts at 2200 hours;
* August 4, 5, 7, 10 and 17, 2017, night shifts at 0600 hours;
* August 2, 3, 4, 13, 15, 16, 22, 27, 29 and 30, 2017, day shifts at 1400 hours;
* August 6, 11, 26 and 30, 2017, evening shifts at 2200 hours;
* July 7, 8, 9, 10, 13, 14, 26 and 29, 2017, night shifts at 0600 hours;
* July 12, 23, 28 and 30, 2017, day shifts at 1400 hours;
* July 19, 23, 24 and 25, 2017, evening shifts at 2200 hours.

Interview and review of the eMAR and eTAR with RPN #111 for resident #001 and #002 stated that the residents were to be reassessed every eight hours for the effectiveness of the device a restraint, registered staff were to document that the reassessment was completed and confirmed that on the above dates it was not completed by the registered staff as required . [s. 110. (2) 6.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and included the person who applied the device and the time of application.

A. On two identified dates, resident #001 and #002 were observed in a chairs with devices applied.
Review of the plans of care identified that they required the devices as restraints.
Review of POC documentation revealed that under "restraint: check device every hour, remove, check skin and reapply every two hours". PSW staff were to document in POC under three follow up questions which were as follows:
i. Type of Restraint/PASD
ii. Restraint/Personal Assistance Service Device Checks which included but were not limited to the time the device was removed, checked, released, repositioned and reapplied
iii. How the resident responded to the restraint.

Interview and review of the home's POC documentation of restraints for both residents with RN #112 confirmed that that there were no follow up questions for the PSW staff to document who applied the devices and the times of the application.
Interview with the Administrator/DOC stated that POC would be updated to include the documentation of who applied the device and the time of application.
B. Resident #003's health record identified that they required the use of a restraint. The POC documentation for the monitoring of the restraint included the checking, releasing, repositioning and reapplying of the device; however, did not include documentation of the application of the device each day, including the name of the person who applied the device and the time of the application. [s. 110. (7) 5.]

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 documentation of a restraint includes the person who applied the device and the time of application and to ensure that the following requirements are met when a resident is being restrained by a physical device under section 31 of the Act: that the resident's condition is reassessed and the effectiveness of the restraining is evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that for the resident who took any drug or combination of drugs, including psychotropic drugs, was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug.

A review of the clinical record identified that resident #048 was ordered a new routine medication in May 2017, which they received the following day.
The medication was identified on the May 2017, electronic Medication Administration Record (eMAR).
Interview with RN #112 identified the current system in the home to monitor the effectiveness of medications directly on the eMAR when a new medication was started or a dosage change for a sufficient period of time as well as the previous system in place to document this information on a paper Pain Flow Sheet.
A review of the May 2017, eMAR did not include documentation of the monitoring of the resident's response and the effective of the drug which was confirmed with RN #112.
A review of the clinical record did not include documentation, specifically a Pain Flow Sheet, as documentation to support the monitoring of the resident's response and the effective of the drug which was confirmed with Administrator/DOC.
The Administrator/DOC identified that he was not able to verify if the monitoring was completed or not, just that he was unable to produce a record of the monitoring of the resident, their response and the effectiveness of the drug. [s. 134. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for the resident who takes any drug or combination of drugs, including psychotropic drugs, that there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug, to be implemented voluntarily.

WN #10: 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. (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 failed to ensure that that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and 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.

On request the home provided the Medication Incident Reports for 2017.
A review of these incident reports identified that the home did not consistently record the immediate actions taken to assess each resident to maintain their health and/or report the incidents to all required persons.
A. Resident #042 was involved in a medication incident in August 2017, which was identified and reported the following day.
A review of the incident report and progress notes did not include immediate actions taken to assess the resident to maintain their health nor notification of the resident, the SDM, the Medical Director, the physician or the pharmacy, as confirmed by the Administrator/DOC following a review of the incident report and clinical record.
B. Resident #043 was involved in a medication incident in May 2017, which was identified and reported two days later.
A review of the incident report and progress notes did not include immediate actions taken to assess the resident to maintain their health nor notification of the resident, the SDM, the Medical Director, the physician or the pharmacy, as confirmed by the Administrator/DOC following a review of the incident report and clinical record.
C. Resident #043 was involved in a medication incident in May 2017, which was identified and reported one and a half months later.
A review of the incident report and progress notes did not include immediate actions taken to assess the resident to maintain their health nor notification of the resident, the SDM, the Medical Director, or the physician, as confirmed by the Administrator/DOC following a review of the incident report and clinical record. [s. 135. (1)]

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

On October 4, 2017, a request was made of the Administrator/DOC to provide the most recent quarterly review of all medication incidents and adverse drug reactions in order to reduce and prevent medication incidents and adverse drug reactions.

The Administrator/DOC identified that the home had just recently become aware of this requirement in August 2017, and since this time had arranged, in conjunction with the pharmacy service provider, to complete a quarterly review of the medication incidents and adverse drug reactions at the October 2017, Professional Advisory Committee; however, as of the time of this inspection this activity had not been completed.

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions. [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 that every medication incident which involves a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is 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, to be implemented voluntarily.

WN #11: 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 interventions were documented.

A. According to the clinical record resident #047 had a change in condition in 2017. This condition was responded to by RPN #126, who identified, during an interview, that they administrated a medication and monitored the resident.
A review of the clinical record did not include all assessments, reassessment, interventions and the resident`s response to the interventions, related to this incident, as confirmed by the RPN and the Administrator/DOC, following a review of the clinical record.
B. According to the Bath Schedule resident #044 was scheduled for two showers a week.
A review of Point of Care (POC) records included that the resident was only showered two times in the current 30 day time period.
Interviews with PSW staff #107, #117 and #127 and the Administrator/DOC each identified that the resident was consistently showered two times a week; however, the documentation was not completed to support this provision of care. [s. 30. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied: alternatives to the use of a PASD had been considered, and tried where appropriate, the use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living, the use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, and the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

On a specified date, resident #001 was observed seated in their chair, in a specific position with a device in place.
The resident was unable to release the device independently.
Review of the plan of care included a Alternatives to Restraints/PASD Checklist assessment completed for the application of the device which included alternatives tried but was not completed for the positioning as a PASD.
Interview with PSW #113 stated the resident was in a positioned chair with a device for positioning and care was provided during the day by staff.
Interview with RPN #111 stated the positioning was a PASD, had a restraining effect and the resident was positioned at family request and for care.
The RPN confirmed there was no documentation for the positioning as a PASD or for alternatives tried in the resident's plan of care, no documented approval for the device and no consent signed by the SDM as a PASD. [s. 33. (4)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any menu substitutions were communicated to residents and staff.

The supper menu for October 5, 2017, indicated that banana cake would be served. During the meal observation it was noted that lemon tarts and not banana cake was served.
Resident #044's SDM voiced concern that the resident was looking forward to the banana cake, as on the menu.
Interview with dietary aide #120 confirmed that their documentation also indicated banana cake was to be served; however, was notified by the kitchen that lemon tarts would be served instead.
The DESN indicated that they were unaware of the menu change from the kitchen; therefore, had not updated the posted menu to reflect this change. [s. 72. (2) (f)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for, the cleaning and disinfection, in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices: supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Interview with PSW #107 verified that the home had a schedule for the cleaning of wheelchairs, which was confirmed by the Administrator/DOC.
It was identified by the PSW that staff on the night shift were to clean the wheelchairs, based on the schedule, and that all chairs were to be cleaned on a weekly basis; however, this was not consistently completed if the chairs were not out in the hall on the designated night and there was no documentation available to support that the cleaning was completed.
Resident #044 used a wheelchair.
According to the schedule and calendar the resident was to have their chair cleaned on a specified date.
The resident was observed in their wheelchair on two dates and on both occasions the chair cushion was noted to be soiled.
During an interview the resident's SDM verbalized that, in their opinion, the chair was not kept clean.
Communication with the Administrator/DOC identified that the home did not have a formalized written procedure developed and implemented specifically for the cleaning and disinfecting of assistive aids; although, confirmed that staff did use a mild disinfectant for cleaning. [s. 87. (2) (b)]

Issued on this 9th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), DIANNE BARSEVICH (581), JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2017_556168_0030
Log No. / No de registre :	023073-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 3, 2017
Licensee / Titulaire de permis :	HALDIMAND WAR MEMORIAL HOSPITAL 206 JOHN STREET, DUNNVILLE, ON, N1A-2P7
LTC Home / Foyer de SLD :	EDGEWATER GARDENS LONG TERM CARE CENTRE 428 BROAD STREET WEST, DUNNVILLE, ON, N1A-1T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Greg Allen

To HALDIMAND WAR MEMORIAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_570528_0013, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall provide education to PSW staff #118 and #119 on the minimizing of restraining before the completion of their next scheduled shifts.

The licensee shall provide education to PSW staff #113, #115, #116, and #117 on the safe use of equipment and transfers before the completion of their next scheduled shifts.

There shall be a record of the training provided to each employee. This record shall include the date that the training was completed, topics covered and who/how the training was completed.

Grounds / Motifs :

1. In keeping with Ontario Regulation 79/10, section 299(1), this Compliance Order is made based on the application of the factors of severity of potential for actual harm/risk, scope of isolated and multiple non-compliance with Compliance Orders in October 2016 and May 2017.

The licensee failed to ensure that all staff who provided direct care to residents, as a condition of continued contact with residents, received training in the following areas: how to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations and any other areas provided for in the regulations.

The licensee failed to ensure that all staff who provided direct care to residents, as a condition of continued contact with residents, received training in the following areas: how to minimize the restraining of residents and where restraining was necessary, how to do so in accordance with this Act and the regulations and any other areas provided for in the regulations.

A. In October 2016, the home was served a compliance order to ensure that all direct care staff received training related to the minimizing of restraining in accordance with the Act and regulations. This order was served again during a Follow Up inspection in April 2017, with a compliance date of June 30, 2017.
The Administrator/DOC identified that the required training was completed in the home by one to one training, small group training and in some cases online training using the Surge Learning Program.
A review of the Staff Sign Off for Restraint Education - February 2017, identified that three percent, or two of sixty-one, direct care staff did not receive the required training on the minimizing of restraining.
Interview with the Administrator/DOC verified that PSW #118 and PSW #119 did not receive the required training, were current employes of the home and were available for work.
On October 6, 2017, interview with PSW #118 identified they could not recall recent training on the minimizing of restraining.
A review of the Surge Course Completion records, for the Minimizing of Restraints and PASD`s, identified that three of the staff, that completed the required training online, completed the training after June 30, 2017. One staff member completed the training on July 24, 2017, another on August 24, 2017 and the third staff member on September 6, 2017.

B. Ontario Regulation 79/10 section 21(2)(2) identifies that "ìf the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs".
In October 2016, the home was served a compliance order to ensure that all staff used safe transferring and positioning techniques when they assisted residents. The licensee was directed to educate all PSW staff on all equipment

used for transferring and positioning. This order served again during a Follow Up inspection in April 2017, with a compliance date of June 30, 2017.
A review of the Lift Training Sign Off provided for the required education, identified that eleven percent, or four of thirty-five, PSW staff did not receive the required training on the use of transferring and positioning equipment.
Interview with the Administrator/DOC verified that PSWs #113, #115, #116 and #117 did not receive the required training, were current employes of the home and were available for work.
On October 6, 2017, interviews with PSW staff #113 and #116 verified that they had not recently received training, at the home, on the safe use of equipment and transfers. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that the decision to use, continue to use, or to discontinue the use of a bed rail(s) is made within the context of an individual resident assessment, using an interdisciplinary team, with input from the resident or the resident's substitute decision maker (SDM) which is consistent with the prevailing practices identified in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003".

The licensee shall assess all residents in the home for the use of bed rails if it is the request of the resident or the resident's SDM.

Grounds / Motifs :

1. In keeping with Ontario Regulation 79/10, section 299(1), this Compliance Order is made based on the application of the factors of severity of potential for actual harm/risk, scope of widespread and ongoing non-compliance with a VPC or CO.
Previous non compliance was identified related to Ontario Regulation 79/10 section 15(1)a in March 2015, as a VPC.

The licensee failed to ensure that where bed rails were used, the resident was assessed, his or her bed system was evaluation in accordance with evidence-

based practice and, if there were none, in accordance with prevailing practices, to minimize the risk to the resident.

Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), the decision to use, continue to use, or to discontinue the use of a bed rail would be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the resident's substitute decision maker (SDM). The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4). Consideration of these factors would more accurately guide the assessor in making a decision, with either the resident or by the resident's SDM about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A. Review of the plan of care for resident #030 identified they had bed rails raised on their bed for safety when admitted to the home in 2017; however, there was no bed rail assessment completed.
On an identified date, the resident's bed was observed with no bed rails in place.

Interview with PSW #107 stated the resident previously had bed rails but that they were removed several months ago.
Interview with the Administrator/DOC indicated that the home removed most of the bed rails off the residents' bed in May 2017 and confirmed that the home did not complete a bed rail assessment when the resident was admitted, nor prior to removing the bed rails.
B. Review of the plan of care identified that resident #044 had bed rails raised when in bed, when admitted to the home in 2017, for safety; however, there was no bed rail assessment completed.
Interview with RN #100 stated the resident previously had bed rails on their bed but that they were removed several months ago.

Interview with the Administrator/DOC confirmed that a bed rail assessment was not completed when the resident was admitted, as the home did not complete bed rail assessments until May 2017. They also confirmed that a bed rail assessment was not completed when the bed rails were removed from the bed to determine if the resident still required the use of the bed rails.
C. According to the clinical record resident #048 requested the use of bed rails, the day following their admission in 2017 and progress notes confirmed the use of the rails.
The SDM was contacted the same day and verbally agreed to the use of the rails and a consent was signed the following day.
The Minimum Data Set (MDS) assessment completed January 2017, identified that other types of bed rails were used - for example half or one side rail, daily.
The MDS assessment and Alternatives to Restraints/PASD (Personal Assistance Services Device) Checklist, both completed in April 2017, noted that the resident did not use rails; however, the Resident Assessment Protocol (RAP) for the same time period identified the use of rails.
Progress notes of May 2017, identified that on an identified date, at 0300 hours, the bed rails were down and were raised on request.
A note the following day, at 0034 hours, identified that the resident requested to have the bed rails up.
A progress note in July 2017, identified that the resident did not use bed rails in bed.
The MDS assessment completed in July 2017, identified that bed rails were not used.
A review of the clinical record did not include any assessment related to the use of bed rails prior to the initial application or during any of the removals.
Interview with the Administrator/DOC confirmed that bed rail assessment were not completed until May 2017. [s. 15. (1) (a)] (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the registered dietitian (RD), who is a member of the staff of the home, completes a nutritional assessment for all residents, including resident #004, whenever there is a significant change in the resident's health condition; and assesses the resident's hydration status, and any risks related to hydration.

The plan shall include, but not be limited to:
A. * A review of the current written procedures in place related to communication between nursing and dietary staff in regards to residents' fluid intake and hydration levels, including the completion of hydration referrals to the RD and related to assessing residents' changes in condition, hydration status and risk levels for residents, and changes to be made; and
* A review of the actual practices in place related to communication between nursing and dietary staff in regards to residents' fluid intake and hydration levels, including the completion of hydration referrals to the RD and related to assessing residents' changes in condition, hydration status and risk levels for residents, and changes to be made; and
* A revision of the appropriate procedures to ensure that they are reflective of the expectations of the home to ensure effective communication between nursing and dietary staff in regards to residents' fluid intake and hydration levels, including the completion of hydration referrals to the RD and that there is an interdisciplinary assessment of residents' changes in condition, hydration status and risk levels for residents, and changes to be made.
B. Each registered nursing staff member, the RD and the DESM will each receive training on the revised procedures and direction to comply with the procedures.

The plan should be submitted via email by November 23, 2017, to Jessica Paladino via e-mail at HamiltonSAO.MOH@ontario.ca.

Grounds / Motifs :

1. In keeping with Ontario Regulation 79/10, section 299(1), this Compliance Order is made based on the application of the factors of severity of actual harm/risk, scope of isolated and previous WN (similar area).

The licensee failed to ensure that the RD, who was a member of the staff of the home, completed a nutritional assessment for residents whenever there was a significant change in the resident's health condition; and assessed the resident's hydration status, and any risks related to hydration.

Progress notes by the RD were reviewed from resident #004's admission in 2016, until June 2017, whereby each quarterly review indicated that the resident was below their daily fluid target.
One progress note, in 2017, identified that the resident needed encouragement to drink their fluids.
The Nutrition/Hydration Risk Identification Tool completed in September 2017, by the RD, identified that the resident was at a moderate nutritional risk due to poor fluid intake.
The resident's fluid intake records from the Point of Care (POC) documentation program, over one month, were reviewed.
The POC records revealed that the resident was below their target fluid requirement for 22 out of the 32 days, ranging from 125 ml to 1,125 ml per day.

The home's policy, Hydration Management Policy, NC-03-220, last reviewed April 9, 2014, indicated that registered nursing staff would complete and send a dietary department requisition/referral form to the Nutrition and Food Service department when a resident consistently had a poor fluid intake of less than 1,500 cubic centimetres (cc) per day for three days or more. Once a referral was sent, the DESN would refer the resident to the RD to complete an assessment.

In an interview with the RD, on October 5, 2017, they indicated that they were the only person responsible to review and assess resident fluid records, not nursing staff; therefore, they did not receive any poor fluid intake referrals for any residents.
They indicated that they only reassessed a resident's hydration status quarterly and that they were not aware of resident #004's poor fluid intake, having consumed less than their target fluid requirement, and had not received any referrals when the resident consumed less than 1,500 ml per day as per policy. [s. 26. (4) (a),s. 26. (4) (b)]c) per day for three days or more. Once a referral was sent, the DESN would refer the resident to the RD to complete an assessment.

In an interview with the RD, on October 5, 2017, they indicated that they were the only person responsible to review and assess resident fluid records, not nursing staff; therefore, they did not receive any poor fluid intake referrals for any residents.
They indicated that they only reassessed a resident's hydration status quarterly

and that they were not aware of resident #004's poor fluid intake, having consumed less than their target fluid requirement, and had not received any referrals when the resident consumed less than 1,500 ml per day as per policy. [s. 26. (4) (a),s. 26. (4) (b)] (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that a Registered Nurse (RN), who is an employee of the home, is scheduled to work in the home and on duty and present at all times except as provided for in the regulations.

To achieve this requirement the licensee shall develop written strategies to recruit, hire and retain RNs, who will hold the position of an employee of the licensee and a member of the regular nursing staff, and implement the strategies to an effort to ensure coverage of vacation relief and sick or absent calls for regular RNs.

Grounds / Motifs :

1. In keeping with Ontario Regulation 79/10, section 299(1), this Compliance Order is made based on the application of the factors of severity of potential for actual harm/risk, scope of isolated and ongoing non-compliance with a VPC or CO.
This legislative reference was previously identified as non compliant as a VPC March 2015, October 2016 and April 2017.

The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation).

Review of the registered nursing staffing schedule from July 1, 2017, until October 1, 2017, identified that a Registered Nurse (RN) that was a member of the regular nursing staff was not on duty and present at all times, on the following dates:
* On July 6, 2017, from 1500 until 2300 hours, on evening shift;
* On July 11, 2017, from 1500 until 1900 hours of the evening shift;
* On July 23, 2017, from 0700 until 1100 hours on the day shift;
* On August 3, 2017, from 1500 until 1900 hours on the evening shift;
* On August 10, 2017, from 0700 until 1500 hours on the day shift and from 1500 until 1900 hours on the evening shift; and.
* On September 25, 2017, from 1900 until 2300 hours on the evening shift.

Interview with the Administrator/DOC stated there was no RN in the building on the shifts listed above and confirmed that the home was unable to staff those shifts with an RN who was an employee of the home. (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 05, 2018

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that where the Act or this Regulation requires the licensee to have, a procedure, that the procedure is complied with, specifically the four procedures as identified below:

1. Procedure identified as Diabetes Hypoglycemia/Insulin Reaction, N-19-11.
i. The licensee shall continue their review and revision of the procedure to ensure that it provides clear direction to staff providing care.
ii. The final procedure shall be provided to all registered nursing staff, with direction to comply with the procedure and the procedure shall be available and accessible in each medication room for reference.
iii. A record shall be created to identify the staff that reviewed the procedure, the date of receipt and that they are aware of their responsibility to comply with it.

2. Procedure identified as Medication Administration, N-24-20.
i. The licensee shall provide the procedure to all registered nursing staff, including RN #100, and the procedure shall be reviewed at a Registered Staff Meeting with direction to comply with the procedure, which shall be recorded in the Meeting Minutes.
ii. A record shall be created to identify the staff that reviewed the procedure, the date of receipt and that they are aware of their responsibility to comply with it.

3. Procedures identified as Nutrition & Hydration Monitoring Form for Meals & Snacks, NC-03-230 and Clinical Records, N-4-10.
i. The licensee shall provide the procedures to all PSWs, including PSW #103, and the procedures shall be reviewed at a Personal Support Workers Staff Meeting with direction to comply with the procedures, which shall be recorded in the Meeting Minutes.
ii. A record shall be created to identify the staff that reviewed the procedures, the date of receipt and that they are aware of their responsibility to comply with them.

Grounds / Motifs :

1. In keeping with Ontario Regulation 79/10, section 299(1), this Compliance Order is made based on the application of the factors of severity of potential for actual harm/risk, scope of isolated and ongoing non-compliance with a VPC or CO.
This legislative reference was previously identified as non compliant as a VPC in October 2016.

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

A. LTCHA, 2007 section 8, identifies that "every licensee of a long-term care home shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of all residents".

The home had a procedure Diabetes: Hypoglycemia/Insulin Reaction, N-19-11, dated January 31, 2016.
This procedure included a process flow for staff to follow when a resident demonstrated signs and symptoms of hypoglycemia.
This process flow identified that if a resident's capillary blood sugar (CBG) was low (less than three) staff were to take the following action:
A. If the resident was conscious and cooperative give three ounces (oz) orange juice with one tablespoon (tbsp) sugar, follow with half (1/2) a piece of bread or cookie and a glass of milk. Staff were then to monitor the resident for five to ten minutes. If the resident's condition remained unchanged then recheck the CBG and if the results of the test was greater than the last CBG, give a glass of milk and a sandwich, monitor for another five to ten minutes and recheck CBG and add to next Doctor's Day.
B. If the resident was conscious and resistive/uncooperative give glucagon, monitor, recheck CBG, repeat glucagon if not improved, recheck CBG, notify doctor if not improving, if resident conscious, repeat CBG.

An identified resident had a diagnosis and a physician's order for insulin.
A review of the CBG records and progress notes identified that the resident had episodes of hypoglycemia over a four day period of time in 2017.
A review of the clinical records identified that on each occasion of hypoglycemia staff did not consistently follow all of the actions as identified in the procedure.
Interview with RPN #126, who worked during one of the incidents was shown a copy of the procedure Diabetes: Hypoglycemia/Insulin Reaction, N-19-11, dated January 31, 2016, and identified that she was not familiar with the document.
Interview with RN #112 who responded to another incident confirmed that the procedure Diabetes: Hypoglycemia/Insulin Reaction, N-19-11, dated January 31, 2016, was not readily available for staff, was not posted in the first floor medication room, and that they did not consistently follow the process flow during the incident.
Documentation of two additional incidents of hypoglycemia, were reviewed with the Administrator/DOC.

Following a review of the records the Administrator/DOC verified that the procedure was not consistently followed as required.
The Administrator/DOC revealed that the home had just recently requested the Nurse Practitioner to review the policy to ensure that it provided clear direction and was consistent with prevailing practices.
The Administrator/DOC confirmed that staff did not consistently follow the policy in the examples identified above and identified some areas where they would like to see the policy strengthened.

B. Ontario Regulation 79/10, section 114 identifies that "the licensee shall have written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home".

The home had a procedure Medication Administration, N-24-20, dated March 12, 2010, which identified that during the administration of medication staff were to "remain with the resident until it is swallowed".

On an identified date a portion of a medication pass was observed.
i. Resident #041 was observed to have their medication prepared according to the electronic Medication Administration Record (eMAR) by RN #100.
The RN placed the prepared medication in the resident's room, in the presence of the resident and informed the resident that the medication was present prior to leaving the room.
The RN did not observe the resident take or swallow the medication.
The RN identified that the resident was alert, was able to take the medications and that there was no specific order from the physician for the medications to be self administered.
ii. Resident #004 was observed in the dining room with a medicine cup, which contained tablets, in front of them at 1310 hours, with no staff in direct attendance.
RN #100 was identified to be in the servery of the dining area.
Inspector #586 identified that they observed RN #100 place the medication cup in front of resident #004 at approximately 1245 hours, prior to leaving the area.

At 1316 hours, the RN returned to the resident, spoke with them, placed the medications on a spoon and administered them to the resident.

On an identified date, at 1148 hours, resident #049 was heard in a discussion

with RN #100 regarding medications.
The resident identified that they did not recall taking a medication this morning and directed the RN to go to their room and look for them, if they were still in their room, just to place them in the bedside table drawer for later.
The RN immediately visited the resident's room and returned to the nursing station with a pill cup, which she confirmed contained medications.
When questioned the RN confirmed that the medications were found in the resident`s room and removed.
The RN informed the resident that the medications were removed from their room prior to taking them into the medication room.

Interview with the Administrator/DOC identified that the home had a number of residents who were able to administer their own medications; however, at this time they did not have orders in place to support this activity.

C. Ontario Regulation 79/10, section 68, requires "an organized program of nutrition care and dietary services, including the development and implementation of policies and procedures".

i. The home had a policy, Resident Weights, NC-03-140, last revised January 12, 2011. This policy identified PSW's were to weigh each resident by the fifth of the month and submit the weights to the DESN. The weights would be reviewed by the RD and inputted into Point Click Care (PCC), and any weight difference of 2.5 kilograms (kg) from the previous months' weight would require a re-weigh, so a Monthly Weight Assessment Tool would be initiated and returned to the units to be completed within 24 hours and returned to the DESN/RD.

Resident #005's plan of care indicated that they were at a high nutritional risk due to a history of significant weight change and other concerns. The resident experienced a significant weight change, a decrease, over a one month period of time. The RD identified the weight loss and completed the re-weigh tool for staff to complete. Review of the tool and interview with the RD, identified that approximately one week later the re-weigh had still not yet been completed by staff.
Resident #005 did not receive a re-weigh according to the home's policy.

ii. The home had a policy, Nutrition & Hydration Monitoring Form for Meals & Snacks, NC-03-230, last revised April 9, 2014. This policy directed staff to

monitor and document the fluid intake of all residents to ensure adequate nutrition and hydration. An additional policy, Clinical Records, N-4-10, directed staff to ensure documentation in resident health records was complete and accurate.

Resident #004 was observed during lunch meal service in the dining room on an identified date. During the meal, the resident ate 180 ml soup and drank one-quarter of a 250 ml glass of water.
The following day, the resident's intake record from POC was reviewed, which identified that they had consumed 600 ml of fluids at lunch as documented by PSW #103.
In an interview with the PSW the following day they indicated that they had a very busy shift; therefore, had to document after the service and recorded "roughly what [they] usually consume[d]".

Progress notes written by the RD in 2017, indicated for resident #003 that over half of the meals over a one week period of time had no food/fluid documentation, therefore it was difficult to assess average fluid intake, and resident #004's chart identified it was difficult to assess fluid intake due approximately one third of the meals were not documented over a one week period of time.
On October 5, 2017, the RD reviewed resident #004's fluid intake record which identified multiple blank entries or incomplete entries in POC, thereby affecting the fluid totals for the day.
The RD, acknowledged that accurate and complete documentation was needed to ensure appropriate assessment of the resident's intake and risks related to hydration and that the polices were not being followed. [s. 8. (1)] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 05, 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 3rd day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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