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 prévue 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 5, 2018	2018_661683_0016	026272-18	Resident Quality Inspection

Licensee/Titulaire de permis

Haldimand War Memorial Hospital
400 Broad Street West DUNNVILLE ON N1A 1T3

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 BOS (683), AILEEN GRABA (682), CYNTHIA DITOMASSO (528)

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 1, 2, 3, 4, 9, 10, 11, 12, 15, 16 and 17, 2018

The following intakes were completed concurrently with the Resident Quality Inspection:

Complaints:
log #015356-18, IL-57585-HA - related to infection prevention and control, housekeeping, continence care and bowel management, personal support services
log #017864-18, IL-58111-HA /IL-58200-HA - related to nutrition and hydration, personal support services, medication administration

Critical Incident:
log #027038-18, CIS #2963-000008-18 - related to the prevention of abuse and neglect

Follow Up:
log #007954-18 - related to nutrition and hydration and falls prevention and management

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of care, the Director of Environmental Services/Nutrition, the Director of Therapeutic Recreation, the Business Office Manager, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, the Scheduling Clerk/Education Coordinator, the Registered Dietitian, Registered Staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection the inspectors toured the home, reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, observed dining and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
11 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
0 AMP(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2018_560632_0004	528 683

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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 :

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

A review of resident #005's clinical record identified that they were at an identified risk of falls and they had specific interventions in place to prevent falls.

A review of the progress notes indicated that on an identified date, resident #005 had a fall in an identified room with an identified injury. A progress note written by Registered Practical Nurse (RPN) #104 after the fall on the identified date indicated a specific falls prevention intervention was in place, but it was not applied correctly.

In an interview with the Administrator on an identified date, they acknowledged that the identified falls prevention intervention for resident #005 was not applied correctly on an identified date, as per their plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.

A clinical record review indicated that on an identified date, resident #011 was ordered an identified medication, one application as needed for the prescriber to specify under an identified circumstance. According to the medication administration record (MAR), resident #011 was administered the identified medication on an identified date, at an identified time with no effect. A subsequent administration of the identified medication

occurred on the same identified date at an identified time with effect. A review of an identified policy stated that under an identified circumstance, a nursing assessment would be done, where staff were to look at specific areas.

During an interview on an identified date, registered staff #101 stated that resident #011 had a known history of a specific medical condition that required close monitoring. During an interview on an identified date, registered staff #121 reported that if an identified medication was ineffective they would complete an additional assessment of the resident. During the interview, registered staff #121 could not confirm that a reassessment of resident #011 was done as indicated on the identified date when the intervention was deemed ineffective. Registered staff #121 confirmed that the home failed to ensure that resident #011 was reassessed when the identified medical intervention set out in the plan was not effective.

PLEASE NOTE: This non-compliance was identified during complaint inspections log #15356-18 and #017864-18, which were conducted concurrently with the Resident Quality Inspection (RQI). [s. 6. (10) (c)]

Additional Required Actions:

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

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

The licensee failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug.

An identified policy, last revised on an identified date, indicated that specific checks were done according to the physician orders. The residents were reviewed when needed with the physician. In addition, the scheduled medication was commenced and or adjusted by the physician as needed and they also advised regarding specific checks, an identified number of times a day, or to reduce or discontinue the identified checks.

The plan of care for resident #009 identified that the resident had identified medical diagnoses and required identified medications.

The physician order forms and electronic medication administration records (eMARS) from three identified months indicated that on an identified date, the physician ordered a change in an identified medication and in monitoring practices for resident #009. On an identified date, the physician changed the orders for an identified medication and requested monitoring an identified number of times a day for an identified time period. Review of the eMARS did not include any monitoring after an identified date, for an identified time period. On an identified date, the monitoring was restarted until an identified date. Interview with RPN #015 confirmed that the resident required regular monitoring of a specific medical condition. Interview with the RN #102 confirmed that monitoring was missed for resident #009 for an identified time period and on a subsequent identified date. (528) [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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee failed to ensure that staff used all equipment, supplies, devices, assistive devices and positioning aids in the home in accordance with manufacturer's instructions.

A clinical record review revealed that on an identified date, staff #116 attempted to provide care to resident #011 using equipment. Resident #011 had an undesired change in position and staff lowered the resident to the ground. Further record review included a post fall assessment completed by registered staff #105 that indicated a contributing factor to the incident. Progress notes on an identified date stated that resident #011 sustained specific minor injuries as a result of the incident.

A review of the manufacturer's instructions for the equipment provided specific instructions for use.

During an interview on an identified date, registered staff #105 confirmed that the staff did not follow the manufacturer's instructions on the identified date during the provision of care. During an interview on an identified date, staff #116 stated that they did not follow the instructions during the provision of care on the identified date. During an interview on an identified date, the Administrator confirmed that the equipment was not used according to the manufacturer's instructions.

The home failed to ensure that staff used the equipment in accordance with the manufacturer's instructions.

PLEASE NOTE: This non-compliance was identified during complaint inspections log #15356-18 and #017864-18, which were conducted concurrently with the RQI. [s. 23.]

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 use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of the home's policy #N-5-65, "Falls Prevention," last revised on an identified date, defined a fall as "any unintentional change in position where the resident ends up on the floor, ground or other lower level" and further identified "includes witnessed and un-witnessed falls, includes if resident falls onto a mattress placed on the floor and includes whether there is an injury or not." The policy defined a near fall/near miss fall as "a sudden loss of balance that does not result in a fall or other injury. This can include a person who slips or trips that does not result in a fall or other injury. This can include a person who slips, stumbles or trips but is able to regain control prior to falling." The policy identified that registered nursing staff were to complete the post fall assessment with the approved assessment tool.

A review of resident #005's clinical record identified that they were at an identified risk of falls and they had specific interventions in place to prevent falls.

A review of the clinical record for resident #005 identified that they had what the home identified as a near miss fall on an identified date. A review of the progress notes identified that the resident had another near miss fall on an identified date.

A review of the clinical record for resident #005 did not identify post fall assessments for the falls on either of the identified dates.

In an interview with registered staff #102 on an identified date, they indicated that the home considered specific falls to be a near miss fall, because the intervention worked. They identified that they did not do post fall assessments on near miss falls.

On an identified date, Inspector #683 reviewed the home's Falls Prevention policy with the Administrator, including the home's definition of a fall, a near fall/near miss fall, and the responsibilities of the registered staff. The Administrator acknowledged that the home had been treating a specific type of fall as a near miss fall for quite some time and acknowledged that the falls prevention policy had not been updated to reflect the change in practice. In the interview, the Administrator acknowledged that as per the home's current policy, a post fall assessment should have been completed for resident #005's falls on the identified dates. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

The licensee failed to ensure that with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, that the physical device was applied in accordance with the manufacturer's instructions.

On two identified dates, resident #005 was observed in an identified position, in an identified mobility device, with an identified physical device applied. On both observations, the resident's identified physical device was observed not applied in accordance with the manufacturer's instructions, as confirmed by Personal Support Workers (PSWs) #106 and #107 on an identified date, and by RPN #103 and the Administrator on an identified date.

In an interview with PSW #106 and #107 on an identified date, they indicated that they were unable to adjust the physical device as that was done by the home's contracted external service provider. PSW #107 identified that when resident #005 was seated in an identified position in their identified mobility device, the identified physical device was applied correctly. PSW #107 demonstrated this to the Inspector and the Inspector acknowledged that when the resident was seated in an identified position in their identified mobility device, the physical device was applied correctly.

In an interview with the Administrator on an identified date, they acknowledged that resident #005's identified physical device was not applied in accordance with the manufacturer's instructions and identified that they would contact the home's contracted external service provider to request adjustments to the physical device. On an identified date, the Administrator acknowledged the home's expectation for the application of specific physical devices and they agreed that it is what they felt the manufacturer's directions would be in relation to how an identified physical device was to be applied to a resident.

The home did not ensure that resident #005's identified physical device was applied in accordance with the manufacturer's instructions on two identified dates. [s. 110. (1) 1.]

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 with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, that staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

A. On an identified date, for approximately one and a half hours, medication administration was observed on an identified home area. At an identified time, RPN #105 began administering medications to residents in the dining room. When the RPN left the medication cart, which was located outside of the dining room, the cart was left unlocked. The RPN then returned to the cart and dispensed medications from the narcotic bin. The RPN did not need a key to open the drawer and when they were finished they did not close and lock the narcotic bin before closing the drawer. The RPN left the cart and administered medications in the dining room and both the medication cart and narcotic bin were left unlocked. The RPN continued to dispense and administer medication this way, until an identified time when they locked the narcotic drawer. The Long-Term Care (LTC) Homes Inspector was able to open the cart and access the medications, including narcotics, twice throughout the observation, with the RPN's knowledge. Interview with the RPN confirmed that the medication cart and narcotic bin should be secured and locked at all times, when not in use. (528)

B. On an identified date, at an identified time, LTC Homes Inspector #528 observed RPN #117 dispense medication from a medication cart outside of the dining room. They then left the cart to administer the medications, walking down the hallway and around the corner, so the cart was no longer in their sight. The LTC Homes Inspector #528 approached the cart and was able to open the medication drawers of the cart including the narcotic bin, which was noted to be closed but unlocked. When RPN #117 returned approximately a minute later, they confirmed that the medication cart and narcotic bin should have been locked when unattended. (528) [s. 129. (1) (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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

A clinical record review indicated that on an identified date, resident #011 was ordered an identified medication, one application as needed for the prescriber to specify under an identified circumstance. According to the MAR, resident #011 was administered the identified medication on an identified date, at an identified time with no effect. A subsequent administration of the identified medication occurred on the same identified date at an identified time with effect. A review of an identified policy stated that under an identified circumstance, a nursing assessment would be done, where staff were to look at specific areas and the attending physician was to be called for further orders.

During an interview on an identified date, registered staff #121 stated that the physician was not called for further orders when the identified medication administered at an identified time was ineffective. Registered staff #121 stated that resident #011 had been administered an identified medication that was not prescribed to them.

PLEASE NOTE: This non-compliance was identified during complaint inspections log #15356-18 and #017864-18, which were conducted concurrently with the RQI. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #8: 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 :

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.

The licensee failed to ensure that actions related to activities of daily living (ADL) for resident #011 completed by PSW staff were documented.

A clinical record review indicated that resident #011's plan of care, last revised on an identified date, included a specific intervention that was to be completed by PSW staff daily. During an interview, staff #106 indicated that completed tasks related to personal care were documented on the electronic clinical record by staff assigned to the resident. Further clinical record review revealed that there were no initials on the documentation service report beside the identified task indicating that the care was provided to resident #011 on four identified dates. Staff #106 confirmed that the specific intervention for resident #011 was completed daily but that the task was not documented. During an interview on an identified date, the Administrator stated that the home failed to ensure that the actions related to activities of daily living for resident #011 were documented.

PLEASE NOTE: This non-compliance was identified during complaint inspections log #15356-18 and #017864-18, which were conducted concurrently with the RQI. [s. 30. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of Residents Council minutes from an identified date indicated concerns related to the quality of the bacon served in the home. Review of the "Resident Council - Recommendations/Concerns" form included a departmental response eight days later; however, did not include a date that the council had reviewed the response. An interview revealed that they had not yet received a response related to food concerns. An interview with the Director of Therapeutic Recreation confirmed that the home had not yet provided the response to Residents Council and would be doing so at the next meeting. [s. 57. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that they responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A review of Family Council meeting minutes from an identified date described the home's response process for Family Council concerns or recommendations, as follows: the home will have a response within 10 days, which will be reviewed at the next family council meeting. A review of the monthly meeting minutes from an identified month indicated two concerns that were brought forward with identified recommendations. In an interview on an identified date, it was confirmed that concerns and recommendations were raised at the last meeting but the Council had not received a response within 10 days. An interview with the Director of Recreation confirmed that the concerns raised during an identified meeting had been reviewed and actioned on an identified date, however; the response was going to be provided to the Family Council at the next meeting and not within 10 days. [s. 60. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

A clinical record review indicated the following: resident #012, resident #016, resident #017, resident #018, resident #019, resident #020, resident #021 and resident #022 were missing the monthly weight measurements for an identified month. In addition, resident #018 and resident #019 were missing monthly weight measurements for another identified month.

A review of the policy #NC-03-140 "Resident Weights," last revised on an identified date, stated the following: "2. the personal care provider will weigh each resident by the 5th of the month; 3. The monthly weight will be recorded on the resident weight record."

During an interview on an identified date, staff #122 stated that PSW staff weigh each resident within the first five days of every month and record the measurement on the resident weight record. The Registered Dietitian (RD) reviews the resident weight record and enters the weights into the resident's electronic record. The Administrator confirmed that the identified residents did not have their weights recorded for two identified months. The home failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record each resident's monthly weight. [s. 68. (2) (e) (i)]

Issued on this 20th day of November, 2018

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

Original report signed by the inspector.