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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 25, 2016	2016_417178_0010	013476-16	Resident Quality Inspection

Licensee/Titulaire de permis

DEEP RIVER AND DISTRICT HOSPITAL
117 BANTING DRIVE DEEP RIVER ON K0J 1P0

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

THE FOUR SEASONS LODGE
117 BANTING DRIVE DEEP RIVER ON K0J 1P0

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

SUSAN LUI (178), RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): on site on July 19, 20, 21, 22, 25, 26, 27, 28, 2016; off site August 2, 3, 2016.

Complaint intake #018386-16 was inspected concurrently with this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator (Chief Nursing Officer), Director of Care (DOC), registered dietitians, physiotherapist, Nutrition Manager, Manager for IT/Maintenance, Infection Prevention and Control RN, RAI coordinator/telemedicine coordinator, registered staff, personal support workers (PSWs), food service workers, maintenance employee, representative of combined Residents/Family Council, residents, family members of residents.

During the course of the inspection, the inspectors also toured residential and non-residential areas, observed resident care, observed meals and snacks' services, reviewed Home policies and procedures, observed a medication pass, observed recreation activities, reviewed minutes for the combined Residents/Family Council, reviewed Residents' Health Records including plans of care, medication and treatments records, as well as Resident Assessment Instruments of the Minimal Data Set (RAI-MDS), Resident Assessment Protocols (RAPs), PSW Point of Care (POC) documentation, and reviewed training records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 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. 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The Licensee failed to ensure the care set out in the plan of care is provided.

Resident #010 has been identified as having an identified medical condition.

On an identified date, it was observed PSW # 107 to use a cutlery teaspoon to measure out the product Thicken Up and placed it into a 125 millilitre (ml) glass containing approximately 120 mls of soup for resident #010.

During an interview, PSW# 107 indicated he/she used a cutlery teaspoon of Thicken Up and placed it into the resident's soup and would do the same for fluids. PSW# 107 indicated that he/she is not aware of what the required consistency for fluids is for the resident nor, how much of Thicken up is needed to reach the desired thickness.

The resident's care plan on an identified date specified that Thicken Up is to be added to the resident's meals as necessary.

The Resident Assessment Protocol (RAP) Summary Items document on an identified date, indicated that the staff are to thicken the resident's #010 fluids to an identified required consistency.

All resident's diets are identified on a Dietary List dated June 22, 2016, as verified by the Nutritional manager. The list specifies the required consistency for liquids for resident #010. All staff use the list to verify the resident's dietary needs.

On July 19, 2016 the Nutritional manager indicated that all staff preparing liquids to the correct consistency are to follow the directions on the container of Thicken up for its use. The container of Thicken Up used on the unit specifies the amount of product to use for a specific amount of fluid. For resident # 010's required consistency, one tablespoon of Thicken Up is to be added to a 120 ml serving of fluid.

During an interview FSW #104 indicated that he/she added one cutlery teaspoon of Thicken Up for resident #010's juice and a cutlery tablespoon for the resident's soup for lunch service. FSW #104 indicated he/she is aware of where to locate the list of resident dietary needs. FSW #104 indicated that he/she was not aware of the required consistency for liquids for resident #010. [s. 6. (7)]

2. The Licensee failed to ensure the provision of care is documented.

Resident #014 has been identified as moderate nutritional risk.

On July 28, 2016 during an interview the Dietitian indicated that the resident is to be monitored for food and fluid intake as the resident has been identified to be at moderate nutritional risk due to his/her weight, and refusal of identified meals. The Dietitian further indicated that he/she calculates the daily fluid need for the resident and monitors the resident by observing the resident during meal service, assesses the resident's monthly weights and reviews the recorded daily food and fluid intake in POC on the Dietary Report. The Dietitian indicated that he/she has brought forward concerns of the lack of documentation on the Dietary Report of the resident's intake and refusal of meals to the Director of Care. The Dietitian added that the amount of food and fluid and any refusal of a snack or meal is to be recorded in POC as a means to monitor the resident's nutrition and hydration.

During an interview PSW #114 indicated that the resident regularly refuses identified meals, and the resident food and fluid intake is documented in the POC.

The Dietary Report was reviewed from July 1- 27, 2016. The electronic report has dietary item codes that prompt the recording of the percentage of food and fluid intake for breakfast, morning snack, lunch, afternoon snack, dinner and evening snack. Review of the report indicated there is no record of the resident's food and fluid intake for breakfast , morning snack, lunch and dinner for July 9, 2016. On July 13, 20, 21, 24, 25, 26, 2016 there is no record of the resident refusal or amount of intake for morning snack. On July 6, 9, 26, 2016 there is no record of the resident refusal or intake for lunch. On July 7, 8, 9, 13, 14, 15, 16, 17, 18, 24, 25, 26, 27, 2016 there is no record of resident refusal or amount of intake for afternoon snack. On July 8 and 26, 2016 there is no record of the resident's refusal or intake for dinner. Lastly, there is no record on July 1, 3, 4, 6, 8, 9, 10, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 24, 25, 26, 27, 2016 for evening snack.

On July 28, 2016 during an interview the DOC stated that the personal support workers are expected to document all resident intake and their refusal on a daily basis for the monitoring of nutrition and hydration needs. She further indicated that she is aware there is an issue with the consistent recording of resident food and fluid intake.

In this matter, the Licensee failed to ensure the documentation of resident's #014 food

and fluid intake. [s. 6. (9) 1.]

3. The Licensee failed to ensure the provision of care is documented.

Resident #004 has been identified as moderate nutritional risk. The resident's care plan specifies that the resident's fluid intake on a daily basis is to be documented.

On July 27, 2016 during an interview PSW #121 indicated that when the resident refuses an identified meal, the resident is offered a replacement nutrition source. PSW#121 indicated the documentation of both meal and fluid intake is completed in the POC.

On July 28, 2016 during an interview the Dietitian indicated that the resident is to be monitored for food and fluid intake as the resident has been identified to be at moderate nutritional risk due to his/her weight and refusal for meals. The Dietitian further indicated that she calculates the daily fluid need for the resident and monitors the resident by observing the resident during meal service, assesses the resident's monthly weights and reviews the recorded daily food and fluid intake in POC on the Dietary Report. The Dietitian indicated that she has brought forward her concerns of the lack of documentation on the Dietary Report of the resident's intake and refusal of meals to the Director of Care. The Dietitian added that the amount of food and fluid and any refusal of a snack or meal is to be recorded in POC as a means to monitor the resident's nutrition and hydration.

The Dietary Report was reviewed from July 1- 27, 2016. The electronic report has dietary item codes that prompt the recording of the percentage of food and fluid intake for breakfast, morning snack, lunch, afternoon snack, dinner and evening snack. Review of the report indicated there is no record of the resident's food and fluid intake for breakfast for July 9 and July 25, 2016. On July 9, 25, 26, 27, 2016 there is no record if morning snack was taken or refused. On July 9 and 25, 2016 there is no record if the resident refused or had lunch. On July 7, 8, 10, 13, 14, 15, 21, 22, 23, 24, 25, 26 and 27, 2016 there is no record of resident intake of afternoon snack. On July 8 and 25, 2016 there is no record of the resident's intake for dinner and no record of the resident's intake for evening snack with an exception of one day, July 5, 2016.

On July 28, 2016 during an interview the DOC stated that the personal support workers are expected to document all resident intake and their refusal on a daily basis for the monitoring of nutrition and hydration needs. She further indicated that she is aware there is an issue with the consistent recording of resident food and fluid intake.

In this matter, the Licensee failed to ensure the documentation of resident's #004 food and fluid intake. [s. 6. (9) 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 the care set out in the plan of care is provided, and the the provision of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.

Observations of the washroom for resident #001 on July 20, 21 and 22, 2016, revealed that the call bell was present, but the string was wrapped around the back of the grab bar in such a manner as to make the call bell inaccessible to a person sitting on the toilet.

Review of the resident's care plan indicated that the resident walks independently, and uses the toilet independently.

Interview with PSW #111 confirmed that the resident uses the toilet independently. On July 22, 2016, PSW #111 accompanied the inspector to observe the call bell wrapped around the back of the grab bar, and confirmed that it would not be accessible to the resident while on the toilet. PSW #111 confirmed that all residents should have the call bell accessible in the washroom, in case they become weak and need to alert staff. PSW #111 adjusted the grab bar into position and re-wrapped the call bell string in such a way that it would be accessible to the resident when the resident uses the toilet..

On July 25, 2016, the inspector demonstrated to the DOC how resident #001's bathroom call bell was positioned on July 20, 21 and 22, 2016.
The DOC confirmed that this would have been inaccessible to the resident and confirmed that the resident requires access to the call bell within the washroom for safety. [s. 17. (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 the home has a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of resident #013's progress notes revealed that the resident sustained a number of identified areas of altered skin integrity during June and July 2016.

During interviews, RPNs #119, #113, and #110 all confirmed that when a resident has impaired skin integrity it should be assessed using the home's electronic skin assessment tool, called Wound Tracker. Review of the resident's Wound Tracker electronic records revealed that none of the above identified areas of impaired skin integrity had been assessed using the home's clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

During an interview on July 26, 2016, RPN #113 was unable to find assessments on Wound Tracker for the above identified areas of impaired skin integrity.
During an interview on August 2, 2016, RPN #123 and the home's DOC confirmed that no assessment of the above identified areas of impaired skin integrity appeared to have been done using the home's clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: 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:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

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).

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:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirement was met with respect to the restraining of a resident by a physical device. The physical device is well maintained.

On July 19, 2016 resident #005 was observed by inspector #548 at an identified time to have a lap belt applied while seated in a wheelchair. It was observed that there was a measurement of five to six finger width gap between the resident and the lap belt.

On July 21, 2016 resident #005 was observed at an identified time to have a lap belt applied while seated in a wheelchair. It was observed that there was a measurement of

five to six finger width gap between the resident and the lap belt.

The health care record was reviewed.

The resident #005 is totally dependent on staff for activities of daily living and is cognitively impaired. The Resident Assessment Protocol on an identified date indicated that the resident exhibits identified repetitive physical movements, is not cognitively aware nor physically able to remove the lap belt. The resident's primary mode of locomotion is a wheelchair.

On July 25, 2016 resident #005 was observed to have the lap belt applied while seated in the wheelchair. The resident was exhibiting identified repetitive movements. The lap belt gap remained to have a five to six finger width gap between the resident and the lap belt. During an interview PSW #114 indicated that he/she had placed the resident in the chair and had applied the lap belt. The PSW #114 indicated that the lap belt was "loose" and readjusted the lap belt to fit snugly across the resident's thighs.

On July 28, 2016 in the presence of the DOC the resident was observed at an identified time to be in the wheelchair with the lap belt applied. The resident was exhibiting identified repetitive movements. The lap belt is a front closure belt with a push button release and an adjustable black strap. The lap belt was observed by Inspector #548 in the presence of the DOC, to be loose approximately five to six finger width gap between the resident and the lap belt. While the Inspector held the lap belt black strap became loose in its entirety to the front of the buckle. The DOC readjusted the lap belt to fit snugly across the resident's thighs and held the lap belt buckle. The lap belt strap became loose in its entirety to the buckle. The DOC indicated that the buckle was not functioning properly and asked the staff to remove the resident from the wheelchair into bed.

On July, 28,2016 the physiotherapist indicated that the lap belt was not functioning properly. The DOC called the occupational therapist to assess the lap belt.

Manufacturer instructions for the lap belt were requested on July 22, 2016 and again on July 28, 2016. At the time of the inspection the instructions were not provided.

2. The licensee failed to 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: the person who applied the device and the time of application.

As per the above finding, s. 110.(1)2, resident #005 was observed on July 19, 21, and 25, 2016, to have a lap belt applied while seated in a wheelchair.

During an interview on July 28, 2016, RPN #110 indicated that the resident is repositioned every two hours and that he/she records that the resident was checked every hour and the lap belt was removed every two hours by the personal support workers.

The home's policy titled: Minimizing of Restraining of Residents, Policy R-035, Revision date: 2015 was reviewed and specifies for staff to document every hour on the restraint monitoring record and every two hours when the restraint is released and the resident is repositioned.

During an interview the DOC indicated the resident routine is to be placed in the wheelchair and the physical device applied at an identified time in the morning and remains in the chair until the afternoon nap and then again the resident is placed in the wheelchair with the physical device applied for supper meal.

The PASD/Restraint document from July 1-31, 2016 was reviewed. There is no record of who applied the device or the time of its application on July 1, 5, 7, 10, 11, 25 and 27, 2016.

3. The licensee failed to 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: all assessment, reassessment and monitoring, including the resident's response.

As per the above finding, s. 110.(1)2, resident #005 was observed on July 19, 21, and 25, 2016, to have a lap belt applied while seated in a wheelchair.

During an interview on July 28, 2016, RPN #110 indicated that the resident is repositioned every two hours and that he/she records that the resident was checked every hour and that the lap belt was removed every two hours by the personal support workers (PSWs). RPN #110 indicated that he/she receives verbal confirmation that the

PSWs have completed this. The RPN indicated that he/she does not document the resident's response to the restraint.

The home's policy titled: Minimizing of Restraining of Residents, Policy R-035, Revision date: 2015 specifies for staff to document every hour on the restraint monitoring record and every two hours when the restraint is released and the resident is repositioned.

Review of the resident's health care record resulted in no documentation of the resident's response to the lap belt. During an interview the DOC indicated that the resident's response to the device is not recorded in the health care record.

4. The licensee failed to 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: every release of the device and all repositioning.

As per the above finding, s. 110.(1)2, resident #005 was observed on July 19, 21, and 25, 2016, to have a lap belt applied while seated in a wheelchair.

During an interview on July 28, 2016, RPN #110 indicated that the resident is repositioned every two hours and that he/she records that the resident was checked every hour and the lap belt was removed every two hours by the personal support workers.

The home's policy titled: Minimizing of Restraining of Residents, Policy R-035, Revision date: 2015 specifies for staff to document every hour on the restraint monitoring record and every two hours when the restraint is released and the resident is repositioned.

Review of the resident's health care record resulted in no documentation of when the lap belt is released or when the resident was repositioned.

During an interview the DOC agreed there was no record of when the lap belt is released or when the resident was repositioned. [s. 110. (1) 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 the following requirements are met with respect to the restraining of a resident by a physical device:
-the physical device is well maintained
-every use of a physical device to restrain a resident under section 31 of the Act is documented, including, the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response, and every release of the device and all repositioning, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that includes its protocols for referral of resident to specialized resources where required.

Review of the home's skin and wound program revealed that the program's written policy titled Pressure Ulcer Prevention and Wound Care (policy #P-040, dated as Reviewed Oct 2012, Revised Nov 2015) does not include protocols for referral of the resident to specialized resources where required. The policy states under the heading Assessing High Risk Residents, "consult wound care specialist as necessary". No further explanation is present regarding when this consult might be necessary, what type of wound specialist should be consulted, and how the referral should take place.

The policy also states under the heading Hydration and Nutrition Consult, that "the resident's hydration will be maintained and a dietitian consult initiated as indicated". No explanation is offered regarding what "as indicated' means in this case, or how the referral process should take place.

During an interview on July 28, 2016, the home's DOC confirmed that the home's Skin and Wound program does not have a written description of the program which includes protocols for referral of resident to specialized resources where required. [s. 30. (1) 1.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. This finding is related to Log #018386-16/IL-45153-OT
The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of resident #013.

Observations of resident #013, and review of his/her plan of care confirmed that the resident has an identified medical condition which requires daily care.

Interviews with resident #013's family revealed that at the time of admission, the home's staff informed them that the family will be required to provide or pay for the supplies necessary for providing one identified aspect of the daily care related to the resident's identified condition.
The resident's family confirmed that since the resident's admission to the home on an identified date, they have provided the supplies necessary for providing one identified aspect of the daily care related to the resident's identified condition, at their own expense.

Interview with the home's DOC confirmed that she did inform the resident's family that either they or their insurance company would be billed for the supplies necessary for providing one identified aspect of the daily care related to the resident's identified condition.

As per the Ministry of Health and Long-Term Care's Guideline for Eligible Expenditures for Long-Term Care Homes, Updated: February, 2013, the supplies necessary for providing one identified aspect of the daily care related to the resident's identified condition are to be made available by the home, for the resident's nursing and personal care needs. [s. 44.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

This home has a combined Residents/Family Council. Interview with a representative of the Council revealed that meal and snack times have not been reviewed at Council meetings.

Review of the Residents/Family Council minutes for October 2015 to March 2016, and May 2016 to July 2016 revealed that review of meal and snack times was not included in the minutes of any of the meetings.

During interviews, the home's DOC, Chief Nursing Officer (CNO), Nutrition Manager, and Registered Dietitian all confirmed that meal and snack times have not been reviewed with the Residents/Family Council. [s. 73. (1) 2.]

Issued on this 9th day of September, 2016

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

Original report signed by the inspector.