

Specifically failed to comply with the following subsections:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,

- (a) the Residents' Bill of Rights;
- (b) the long-term care home's mission statement;
- (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
- (d) an explanation of the duty under section 24 to make mandatory reports;
- (e) the long-term care home's procedure for initiating complaints to the licensee;
- (f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
- (g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
- (h) the name and telephone number of the licensee;
- (i) an explanation of the measures to be taken in case of fire;
- (j) an explanation of evacuation procedures;
- (k) copies of the inspection reports from the past two years for the long-term care home;
- (l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;
- (m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years;
- (n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;
- (o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;
- (p) an explanation of the protections afforded under section 26; and
- (q) any other information provided for in the regulations. 2007, c. 8, ss. 79 (3)

Findings/Faits saillants :

1. The licensee did not ensure that there was notification of the home's policy related to minimizing of restraints posted.
[s.79(3)(g)]

a) A review of the posted information at the home revealed that notification of the home's policy related to minimizing of restraints was not posted.

b) Discussions with the administrative assistant and the administrator confirmed that this information was not posted.

2. The licensee did not ensure that the policy to promote zero tolerance of abuse and neglect of residents was posted.

a) During a review of the posted information at the home, it was noted that the home's policy related to zero tolerance for abuse and neglect was not posted.

b) Discussions with the administrator confirmed that this policy was not included in posted information.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following subsections:

s. 78. (2) The package of information shall include, at a minimum,

- (a) the Residents' Bill of Rights;
- (b) the long-term care home's mission statement;
- (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
- (d) an explanation of the duty under section 24 to make mandatory reports;
- (e) the long-term care home's procedure for initiating complaints to the licensee;
- (f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
- (g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
- (h) the name and telephone number of the licensee;
- (i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91
- (l) for each type of accommodation offered in the long-term care home;
- (j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;
- (k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;
- (l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
- (m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;
- (n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;
- (o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
- (p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;
- (q) an explanation of the protections afforded by section 26; and
- (r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee did not ensure that the home's admission package included the home's policy to promote zero tolerance of abuse and neglect of residents.[s.78(2)(c)]

- a) A review of the admission package that was provided by the home did not include the home's policy related to zero tolerance for abuse and neglect.
- b) During an interview the administrator confirmed that the admission package did not include the home's policy related to zero tolerance for abuse and neglect.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program



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
prévus le Loi de 2007 les
foyers de soins de longue

Specifically failed to comply with the following subsections:

s. 229. (2) The licensee shall ensure,

- (a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
- (b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
- (c) that the local medical officer of health is invited to the meetings;
- (d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
- (e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the infection prevention and control program is an interdisciplinary team approach in the co-ordination and implementation of the program and meets at least quarterly and that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [r.229(2)(d)]

A. Interview with the Assistant Director of Care (ADOC) confirmed that the home's infection prevention and control program team has not been meeting on a quarterly basis. Review of the home's infection prevention and control program meeting minutes, indicate the home has had four meetings between February 18, 2011 to April 20, 2012. The minutes do not reflect an interdisciplinary approach to the program as not all department managers attend the meetings.

B. Interview with the DOC and ADOC confirm that the home has not evaluated or updated the infection prevention and control program in the past year. The management staff could not indicate the last time the program was evaluated according to evidence-based practices or prevailing practices.

Issued on this 5th day of October, 2012

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



**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

**Ministère 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LALEH NEWELL (147), ASHA SEHGAL (159), MARILYN TONE (167), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2012_026147_0013
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Apr 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, May 1, 2, 3, 8, 10, 14, 17, Jul 31, Sep 4, 5, 2012
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF ERIN MEADOWS 2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ASH AGARWAL

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



**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

**Ministère de la Santé et
des Soins de longue durée**

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de soins de longue durée*, L.O. 2007, chap. 8

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan ensuring that all residents of the home are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. The plan is to be submitted electronically to Inspector Laleh Newell, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at laleh.newell@ontario.ca by November 9, 2012.

Grounds / Motifs :



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*

Ministère de la Santé et
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Ordre(s) de l'inspecteur
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1. 1. The licensee failed to ensure that the plan of care for the resident was not reviewed and revised to reflect the changes in the resident's health status and assessed needs. [s. 6.(10)(b)]

A. The plan of care for the resident was not reviewed and revised to reflect the changes in the resident's health status and assessed toileting needs. [6(10)(b)]

(PLEASE NOTE: The above evidence of non-compliance related to an identified resident which was found during Inspection # 2012_064167_0013)

B. Five of six residents identified as experiencing a decline in functional abilities were not reassessed and the plan of care was not revised to address the changing care needs, in relation to the following:[s.6(10)(b)]

i. A Minimum Data Set (MDS) full assessment completed for an identified resident indicated that there had been a decline in functional abilities including related to mobility. The Resident Assessment Protocol (RAP) assessment indicated that this RAP problem will be care planned with the goal of improving. Care plans reviewed prior to this assessment and following this assessment were not revised to reflect the changes in the resident's condition and this was confirmed by the Resident Assessment Instrument (RAI) Coordinator.

ii. A MDS full assessment completed for an identified resident indicates that there has been a decline in functional abilities in relation to bowel function and a deterioration in urinary function. The plan of care has not been revised to reflect the decline in function identified in the assessment. The RAI coordinator confirmed that this was identified as an existing RAP and as a result confirmed that there were no changes made to the care being provided to the resident even though there had been a decline in bowel and urinary function for this resident.

iii. A MDS full assessment completed for an identified resident indicated the resident has experienced a decline in functional abilities related to mobility and transferring.. The RAI Coordinator confirmed that a RAP assessment related to the above noted areas of decline was not completed for this resident and the plan of care for the resident was not altered to reflect these changes in the condition of the resident following the full assessment noted above.

iv. A MDS full assessment completed for an identified resident indicated a decline in functional abilities related to bowel control and bladder incontinence. The RAP does not address the decline in bowel and bladder function. The RAI Coordinator confirmed that there were no actions taken in response to the decline in the resident's condition identified and the plan of care was not revised to address this decline in bowel and bladder function.

v. A MDS full assessment completed for an identified resident indicated a decline in functional abilities related to urinary continence. The RAP indicated that this is an adjusted RAP and the plan of care will be updated with a goal of having more periods of urinary continence. A review of the plan of care indicated that there were not changes to the plan of care to address this decline in urinary continence. The RAI Coordinator confirmed that the plan of care was no revised to address this change in the resident's condition,

vi. An identified resident was identified as palliative due to the decline in condition. The nutritional plan of care was not revised to reflect changes related to changes in food texture. The Director of Food Services confirmed that the resident was not reassessed when the resident's condition changed and the plan of care was not revised to reflect these changes. . (129)

vii. The plan of care for an identified resident did not reflect the current health status of the resident. Review of the progress notes and interview with the nursing staff identified resident was on palliative care measures. Resident health status had declined after an injury. Progress notes and clinical records documented by the registered staff identified resident at high risk for dehydration due to insufficient fluid intake. The plan of care was not reviewed and revised to reflect the current nutritional status in relation to palliative. (159) (129)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Nov 09, 2012



**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

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Aux termes de l'article 153 et/ou
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de soins de longue durée*, L.O. 2007, chap. 8

Order # /

Ordre no : 002

Order Type /

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

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 prepare, submit and implement a plan that the following required policies, procedures, strategies or systems are complied with:

- a. Nutrition and Hydration
- b. Pharmacy Signature Report
- c. Disposal of Discontinued/Expired Drugs and Narcotics
- d. Responsive Behaviour/Aggression Prevention
- e. Palliative/End of Life Care

The plan shall be submitted electronically to Inspector Laleh Newell, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at laleh.newell@ontario.ca by October 31, 2012

Grounds / Motifs :

1. 1. The licensee did not ensure that were the Act or this Regulation requires the licensee to have, institute or otherwise put in place any policies, procedures or strategies, that those policies, procedures or strategies are complied with, in regards to the following: [s.8(1)b]

A) Nursing Policy [Pharmacy Signature Report/MEDISYSTEM], required under the medication management system, O. Reg. 79/10, s.114(1), dated December 2010 indicates the pharmacy will fax a Medication Administration Signature Reminder to each home area 30 minutes before the end of the shift – the team leader will verify the list and check against Medication Administration Record (MAR) to make sure that all medications are signed, if a discrepancy the Director of Care will be notified. The team lead will initial the Signature Reminder and forward to the Director of Care. The Director of Care will complete an audit to verify that there are no missing signatures on the MAR. The Director of Care confirmed that the auditing responsibility identified in this policy has not been complied with. (129)

B) Policy #04-08-10 [Disposal of Discontinued/Expired Drugs and Narcotics] required as part of the medication management program under O. Reg. 79/10, s. 136(1) was not complied with. This policy dated September 8, 2003 directs that discontinued outdated narcotics will be stored in a double locked container in the medication room or in a narcotic drawer of the medication cart. Staff in the home did not comply with this policy when it was noted that discontinued narcotics were being stored in a locked desk drawer in an unlocked office in the home. The Director of Care confirmed that this is the practice within the home for the storage of discontinued/expired narcotics.

This policy also directs that the collection and destruction of discarded medications will be handled by a third party contractor. This policy was not complied with as it was noted that narcotics and controlled drugs, that according to the Director of Care were destroyed, were noted to be stored in a sharps container in the Director of Cares unlocked office. The medications were visible through the lid of the sharps container and it was noted that not all medication were altered or denatured consumption impossible or improbable. The consultant pharmacist indicated that this is not the usual process for the destruction of narcotics and controlled drugs. (129)



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C) Policy [Responsive Behavior/Aggression Prevention] dated January 2011 directed staff to assess residents for risk of responsive/aggressive behaviour and triggers. An identified resident had been demonstrating physical and verbal aggressiveness and socially inappropriate behaviours over the last several months and was receiving mediation to manage these behaviours. Registered staff and the Assistant Director of Care confirmed that this policy had not been complied with, because there were no attempts to determine behavioural triggers for this resident. (129)

D) Policy [Palliative/End of Life Care] required under the organized program of nursing services, LTCHA 2007, c. s. 8(1)(a), dated December 2010 directed staff to have a care conference with the multidisciplinary team, resident, and/or POA when the resident's health status was deteriorating towards end of life. An identified resident was deemed palliative and according to the Registered staff and the Director of Care confirm that a multidisciplinary conference was not held for this resident as per policy. (129)

E) Policy [Nutrition and Hydration (LTC)] required under the organized program of dietary services and hydration, LTCHA 2007, c. 8, s. 11(1), dated April 2012 included in the organized program of nutrition care and hydration program required under O. Reg. 79/10 s. 68(1)(a)(b) directs that Personal Care Aides (PCA) will take note of the meals each resident is served, as well as the total amount of fluids served to each resident to ensure accurate documentation. This policy was not complied with in relation to the following:

i. During two observed meal times, staff did not document an accurate amount of fluids for three identified residents. Review of the The food and fluid flow sheets indicated that all three residents were not an accurate of intake. (159)

F) Policy [Nutrition and Hydration (LTC) dated April 2012 included in the organized program of nutrition care and hydration program required under O. Reg. 79/10 s. 68(1)(a)(b) directs that any resident who consume less than 1500 ml/day for two consecutive days will be referred to the Physician. Refer to the Registered Dietitian on the third (3rd) day of fluid intake less than 1500 ml daily. This policy was not complied with in relation to the following:

i. Review of food and fluid intake record for an identified resident identified fluid consumption most days was less than 1500ml/day. There were no documentation to support that a referral was made to the Registered Dietitian in relation to insufficient fluid consumption for four consecutive days. The policy was not complied with in relation to a referral was not made to the dietitian. (159)

ii. Review of food and fluid intake record of an identified resident identified resident's fluid consumption most days were less than 1500ml/day. There are no documentation to support that the PCA staff reported the fluid intake of < 1500 ml to the registered staff or the resident's refusal to drink as per the home's policy. Resident was subsequently sent to hospital for further assessment for dehydration. (147)

(PLEASE NOTE: The above evidence of non-compliance related to an identified resident was found during inspection #2012_026147_0015)

iii. Review of food and fluid intake record of an identified resident identified the fluid intake most days was less than 1500ml/day. Review of progress notes and interview with nursing staff confirmed a referral was not made to the doctor and the dietitian as required in policy. (129)

G) Policy [Nutrition and Hydration (LTC)] dated April 2012 included in the organized program of nutrition care and hydration program required under O. Reg. 79/10 s. 68(1) (a) (b) directs that Personal Care Aides (PCA) will take note of the meals each resident is served, as well as the total amount of fluids served to each resident to ensure accurate documentation. This policy was not complied with in relation to the following:



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i. The home's Nutrition and Hydration policy dated April 2012 -Tab 07-24, states "each resident will have a Nutrition and Hydration flow sheet and Personal Care Aide will complete the flow sheet accurately". The food and fluid intake record for an identified resident was incomplete with numerous missing entries. Policy states at the end of each meal, the Registered Nursing Staff will review the Nutrition and Hydration binder for completion. Interview with the Assistant Director of Care and a review of food and fluid intake records confirmed that the nutrition and hydration intake records were incomplete and not monitored as the policy. (159) (159)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : ~~Oct 31, 2012~~ Nov 9, 2012 LA

Order # / Ordre no :	003	Order Type / Genre d'ordre :	Compliance Orders, s. 153. (1) (b)
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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 that outlines how the licensee will ensure that:
1. the Registered Dietitian completes a nutritional assessment of all residents when there is a significant change in the residents health condition, specifically related to changes in hydration.

This plan shall include short and long term actions to ensure compliance. The plan shall be submitted electronically to Laleh.Newell@ontario.ca, Nursing inspector, Ministry of Health and Long term Care, Performance Improvement and Compliance Branch Hamilton Service Area Office at by October 31, 2012.

Grounds / Motifs :



Ministry of Health and
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Order(s) of the Inspector
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Ordre(s) de l'inspecteur
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de l'article 154 de la *Loi de 2007 sur les foyers
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1. 1. The licensee has failed to ensure that a Registered Dietitian who is a member of the staff of the home, (a) completed nutrition assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and (b) assess matters referred to in paragraphs 13, 14 of subsection (3). [s.26(4) (b)].

A. The licensee failed to ensure that an assessment of an identified resident's hydration status and risks related to hydration was completed when the resident had a significant change in health status and decline in food and fluid intake.

The Registered Dietitian did not assess the resident's hydration status and risks related to nutrition care. Resident had a decline in food and fluid intake, not meeting the recommended hydration goals. The nutrition assessment completed by Registered Dietitian, did not include an evaluation of the resident's food and fluid consumption. The plan of care included a requirement for the resident's daily fluid intake, however, food and fluid intake documentation reviewed for a two month period, reflected the resident was consuming fluids poorly. The resident was sent to hospital for further assessment.

B. The Registered Dietitian did not complete a nutritional assessment for an identified resident when the resident had a significant change in health status and decline in food and fluid intake.

Review of the progress notes identify the resident had a fall resulting in an injury, nursing staff confirmed that the resident's health status declined after the injury. Dietary assessments did not include nutritional assessment related to inadequate fluid intake and risk of dehydration for resident. The plan of care includes a daily estimated fluid requirement, however, food and fluid intake documentation for the resident was consuming less than the daily requirement.

C. An identified resident was sent to hospital for further assessment of her condition due to dehydration. The attending physician ordered to encourage fluids for the resident. Nutrition and Hydration flow sheet identified the resident was consuming less than the ordered amount of fluids per day, placing the resident at risk for dehydration. (159)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : ~~Oct 31, 2012~~ Nov 9, 2012 LA.

Order # /

Ordre no : 004

Order Type /

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

Pursuant to / Aux termes de :



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector
Pursuant to section 153 and/or
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O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the licensee will ensure that: the plan of care for identified residents will include interdisciplinary assessment process with respect to hydration and risks relating to hydration.

This plan shall include short and long term actions to ensure compliance. The plan shall be submitted electronically to Laleh.Newell@ontario.ca, Nursing inspector, Ministry of Health and Long term Care, Performance Improvement and Compliance Branch Hamilton Service Area Office by October 31, 2012

Grounds / Motifs :



Ministry of Health and
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Pursuant to section 153 and/or
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1. 2. The licensee failed to ensure that an interdisciplinary assessment of hydration status and any risk relating to hydration was completed, with respect to the following; [s.26(3)14]

A. An interdisciplinary assessment of an identified resident's hydration status in relation to dialysis treatment was not completed. The RAP related to dehydration and fluid maintenance completed by RAI Coordinator did not include resident's fluid intake in relation to fluid restriction recommended by the dietitian and risk of dehydration. Interview with the RAI coordinator, Registered Dietitian and nursing staff confirmed that an interdisciplinary assessment and care planning of resident's hydration status and risk related to hydration did not occur for the resident.

B. An Interdisciplinary assessment of an identified resident's hydration status and risks related to hydration was not completed. The triggered dehydration Resident Assessment Protocol summary (RAP) stated resident is to maintain fluid intake with staff encouragement to prevent dehydration. This was contrarily to the fluid consumption of resident recorded by personal care aides and the progress notes documented by nursing staff. The Resident Assessment Protocol (RAP) related to dehydration/fluid maintenance completed by Resident Assessment Instrument Coordinator (RAI Coordinator) did not include assessment of the resident's current fluid intake in relation to recommended fluid intake identified on the resident's plan of care, despite of a history of poor fluid intake. Interview with the RAI Coordinator confirmed that a written care plan for the resident was not developed to address resident's specific health needs. Registered Dietitian and RAI coordinator confirmed that an interdisciplinary assessment did not include resident's hydration status and risk relating to hydration.

C. An Interdisciplinary assessment of an identified resident's hydration status and risk related to hydration was not completed when resident had a decline in fluid intake and did not meet the recommended hydration goals. Interviewed Registered Dietitian and the RAI coordinator confirmed that the triggered RAP summary for dehydration was completed by RAI coordinator without Registered Dietitian's and the nursing staff involvement, an interdisciplinary assessment of resident's hydration status did not occur. The progress notes identified that the resident had a fall with injury. Since then resident's health status has declined. The resident was identified at high nutritional risk for dehydration, poor appetite. (159)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : ~~Oct 31, 2012~~ Nov 9, 2012 LA



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

Ministère 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

REVIEW/APEAL 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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.



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section 154 of the *Long-Term Care
Homes Act, 2007, S.O. 2007, c.8*

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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*

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of September, 2012

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur :

LALEH NEWELL

Service Area Office /

Bureau régional de services :

Hamilton Service Area Office