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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 7, 2014	2014_210169_0009	H-000378-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

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

ALLENDALE
185 ONTARIO STREET SOUTH, MILTON, ON, L9T-2M4

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

YVONNE WALTON (169), ASHA SEHGAL (159), IRENE PASEL (510), KATHLEEN MILLAR (527), VIKTORIA SHIHAB (584)

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): April 9, 10, 11, 14, 15, 16, 17, 2014

A critical incident inspection Log# H-000345-14 and a follow up to orders inspection H-000686-13 were completed as part of this Resident Quality Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Administrative Assistant, Social Worker, Resident Accounts Co-ordinator, Housekeeping/Laundry Supervisor, Building Operations Supervisor, Life Enrichment Supervisor, Director of Nursing and Personal Care, Resident Care Managers, Nutrition Services Supervisors, Registered Dietitian, Nursing staff, housekeeping staff, maintenance staff, dietary staff, Residents and Families.

During the course of the inspection, the inspector(s) observed all care areas of the home, observed meal and snack services, observed laundry services, reviewed clinical records and the reviewed policies and procedures and reviewed minutes of meetings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee did not ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. The pureed food served to residents was not visually appealing. The texture of the pureed food was too runny and created a risk for choking. At the lunch meal April 9, 2014 the texture of the pureed spinach and liver was thin and created risk for choking for residents requiring thickened fluids. At the lunch April 11, 2014 the pureed peas and macaroni and cheese was runny and not cohesive. The pureed food was not an appropriate consistency for residents requiring thickened fluids.
Not all residents were served foods that were nutritious and varied:
The pureed meat loaf served at lunch April 11, 2014 did not appear appetizing, a discoloured ring around the rim of the pureed meat was noted. The Food Service Supervisor confirmed that the planned pureed menu items i.e. vegetables and entrees were precooked and out sourced. The pureed food items were defrosted, and heated in "ISeco heating carts" for more than an hour before served to residents resulted in reduced nutritive value and the appearance (discoloration of food).
The home's four week cycle menu offered to residents on pureed diet was repetitious, did not provide variety of fresh seasonal foods each day from all food groups. Interviewed Food service supervisor and the dietary aide confirmed pureed texture menu did not provide similar choice, and variety of food items as for the regular menu. This was noted and confirmed by the dietary staff during the observed lunch and dinner meal service. The menu served to the residents on pureed diet did not include cold food items e.g. salads. Some cultural foods served were not appropriate food combinations e.g. "dhal served with mashed potatoes".
The Villages of Halton pureed menu indicated week four the planned menu for Monday dinner is served pureed chicken noodle soup and pureed macaroni and cheese at the same meal on the same day, the Sunday planned lunch menu is served pureed lasagna and also for the dinner meal pureed spaghetti, the same food form i.e. pasta x2 on the same day. Instant mashed potatoes are served to residents twice a day at lunch and dinner; there is a lack of variety for the meals.
A review of the Residents' Council and the Residents' Food Committee meeting minutes between January 2013 and March 2014 found ongoing concerns related to food quality. The issues and the comments identified were mushy vegetables, soggy foods, sometime under cooked vegetables and hot food served cold. Residents interviewed reported and confirmed these ongoing issues related to food quality. [s. 11. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every the resident's right to be afforded privacy in caring for his or her personal needs is fully respected.

On April 17, 2014, a Personal Support Worker (PSW) was observed providing individual care to Resident #854 in the resident's room with the door open. The PSW confirmed the expectation was for staff to close the resident's door while providing care, to ensure privacy. [s. 3. (1) 8.]

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 that ensures every resident is afforded privacy in treatment and in caring for their personal needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 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 did not ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with. O. Reg. 79/10, s. 8 (1). r. 8. (1)

The Policy named "Personal Assistance Service Devices (PASD)" (#19-03-01) directs staff to procedures titled "Assessing for the Use of Personal Assistive Service Devices (PASDs)" #19-03-02 and "Monitoring the Resident with PASD's/Reassessing PASD's" #19-03-03.
Procedure #19-03-02 called "Assessing for the Use of PASD's" directs staff in the following manner: "PT/OT (physiotherapy/occupational therapy) will assess and document the resident and recommend PASD's", "an order for the use of a specific PASD from a physician or Registered Nurse (Extended Class) has been received", and "an informed consent has been obtained from the resident or his/her SDM (substitute decision maker) where the resident is incapable of providing informed consent".
Resident #04 was observed in a tilt wheelchair.
The occupational therapist (OT) confirmed that Resident #04 uses a tilt chair as a PASD
PSW staff and registered staff confirmed Resident #04 was cared for using a tilt wheelchair for comfort and positioning. The plan of care revealed there was no PT/OT assessment or documentation, no physician or registered nurse (extended class) order for use of the PASD and no resident/SDM consent for use of the PASD.On April 16, 2014 the OT confirmed there was no PT/OT assessment, documentation or recommendation for use of PASD for Resident #04
Registered staff confirmed there was no consent from Resident #04, or their POA for use of the PASD.

Procedure #19-03-03 called "Monitoring the Resident with PASD's/Reassessing PASD's" directs staff in the following manner: "Residents will be monitored on an hourly basis when the resident is awake, or more often to ensure the resident's comfort, safety and well being".
Review of the plan of care revealed no hourly documentation flow sheets for the monitoring of Resident #04
PSW staff confirmed that hourly monitoring was not done for Resident #04 while they were in the tilt chair [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee of a long-term care home did not 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, (b) is complied with. O. Reg. 79/10, s. 8 (1).

The policy named, "Bed Inventory and Entrapment Assessment" (#06-03-04) directs staff to conduct an assessment for bed inventory and entrapment annually.

Review of Bed Assessment Records revealed Resident #08 last received a bed assessment in October 2012 and Resident #09 last received an assessment in January 2013.

The Building Operations Supervisor confirmed these records were up to date and that an annual inspection was not completed. [s. 8. (1)]

3. The licensee did not ensure that staff complied with policy titled "Resident Weight/Height Monitoring, Procedure #10-01-08", created in February, 2011 and revised in November, 2013. The policy directs staff to reweigh residents within 24 hours if significant weight changes are identified, enter the reweigh value into Point Click Care (PCC) and strike out the previous listed weight if it differed from the previous value. The policy defines significant weight change as equal to or greater than 5% in a month, 7.5% in three months and 10% in six months. The Registered Dietitian (RD) is directed to complete a review of residents with significant weight changes and document the review in PCC under Weight Change Note.

Clinical records for Resident #13, #855, #856, #857, #858, #859, #860, #862, #863, #864 and #865 were reviewed; all residents had documented significant weight changes and did not have a documented reweigh as per policy. Resident #860 had a

gain of 7.5 kilograms (14.4%) in five days on October 4, 2013 and a loss of 12.9 kilograms (20.2%) in two months on August 4, 2013. Resident #856 had a loss of 11.3 kilograms (16.8%) in one month on July 4, 2013 and a gain of 3.9 kilograms (7.3%) in one month on April 7, 2014. Resident #858 had a progressive gain of 15.4 kilograms (26.9%) in three months, January 8 to April 5, 2014. Resident #859 had a documented gain of 7.5 kilograms (9%) in one month on April 7, 2014, a loss of 11.7 kilograms (12.4%) in one month on February 26, 2014 and a loss of 21.4 kilograms (18.3%) in one month on February 6, 2011. Resident #13 had a documented weight loss of 6.5 kilograms (9.4%) in one month.

On April 11, 2014, Weight Change Notes for the residents were reviewed. RD reviews were not documented for Resident #855, #863, #864 and #865 in response to the above significant weight changes as per policy.

b) The licensee did not ensure that staff complied with policy titled "Hydration Programs, Procedure #10-01-01", created in March 28, 2011 and revised in November, 2013. The policy directed Personal Support Worker (PSW) staff to alert registered staff if intake fell below 1500 millilitres each day. Nurses were directed to implement progressive interventions if daily fluid intake fell below 1250 millilitres (10 servings) for two days. The resident would be declared a Hydration Risk after two days of low fluid intake, a Dehydration Risk Alert after four days and a Dehydration Risk Critical after six days. The Extra Fluids Tool was to be implemented once a resident is declared a Dehydration Risk Alert; the SIPS Tool was to be implemented and a Registered Dietitian (RD) referral made once the resident became a Dehydration Risk Critical.

Resident #850 had a low fluid intake of four to nine servings for eight consecutive days, April 7 – April 14, 2014. On April 15, 2014 a nurse and two PSWs in the resident's area were interviewed regarding the hydration policy. Staff were unaware of any hydration tools they could use, nor any resident in the home area currently declared a Dehydration Risk Critical. PSW #1 indicated that a low fluid intake was defined as less than nine servings of fluid daily. PSW #2 stated that the registered staff reviewed hydration records nightly and brought low intake to the PSWs' attention; also indicated that the low intake resident list was kept with nurses, making it difficult for front line staff to know who needs hydration interventions. Nurse #1 indicated that low fluid intake was defined as less than 12 servings daily and that she would observe for one day if this was noted and refer to the RD on day two or three. The nurse indicated that she was certain that no resident required fluid interventions on April 15,

thus there was no need to check fluid intake records and that the RD and Physician would provide interventions if a resident was dehydrated. The RD confirmed on April 22 that no low fluid referrals were made for the resident for the month of April. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures 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 did not ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure that Resident #18 was provided with treatment and services for the Resident's health, safety and well-being. Based on the inaction of the nursing staff, the health, safety and well-being of Resident #18 was jeopardized.

In February, 2014 Resident #18 had a fall resulting in an injury. The resident was assessed by the Registered staff and was found to be unable to weight bear as usual. The Resident was provided with an evening snack and then transferred to bed. Interview with the Personal Support Workers indicated they needed to use the mechanical lift to put the resident to bed that evening as the resident was unable to weight bear, which was unusual for the Resident . The Personal Support Workers also indicated the Resident was screaming and yelling during the transfer and when care was provided later in the evening. They identified to the Registered staff the screaming and yelling was unusual for the Resident and the Registered Nurse indicated the Resident was not being transferred to the hospital. Documentation from the Registered Nurse indicated they were not planning to transfer the resident to the hospital to try to avoid any unnecessary, painful transfers as the resident has other health issues. No pain medication was provided either. One interview with a Personal Support Worker indicated the Resident was shaking in pain. The Registered staff were informed of the significant change in resident condition and identified in the post fall assessment the resident was yelling when touched. The Resident did not receive any pain medication for several hours after the fall when they received a routine dose of pain medication from the medical directives. Note: the medical directives were in place at the time of the fall, however were never administered. The Personal Support Workers identified during interview they were surprised the Resident was not sent out the hospital and remained at the home after the fall. It was only when the x-ray was completed was the Resident transferred to the hospital. The doctor was then notified and transferred to the hospital. The hospital confirmed the Resident had a fracture and subsequently deceased due to the fracture. (according to the coroner).

The inaction of the nursing staff jeopardized the health, safety and well-being of Resident #18 resulting in neglect of the resident. [s. 19. (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 that ensures all residents are not neglected by the nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that when Resident #18 experienced pain that was not relieved by initial interventions, the resident was reassessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #18 had a fall. After the evening snack, the resident was unable to weight bear, so staff used a mechanical lift to transfer the resident to bed. This was not the usual procedure for resident transfers. Staff identified this caused the resident a significant amount of pain and reported it to the registered staff. On the same evening the Personal Support Workers (PSW) turned the resident to change the incontinence brief and identified the resident was still in a significant amount of pain. The PSW's called RPN and RN. The RN and RPN told the PSW they were not going to send the resident to the hospital. Two PSW's identified the behaviour was not the normal for the resident. Another PSW identified the resident was shaking from pain. The PSW's reported to RN resident was screaming and stopped screaming when staff stopped touching them. Resident was also leaning to one side.
Progress notes indicated resident was experiencing pain when moved and MD would be notified to get pain medication. Resident up for meals and was experiencing discomfort when transferred into wheelchair and was hesitant to get up from bed to wheelchair. The Resident was given routine pain medication. Dr notified and an x-ray ordered to assess the resident. Resident having facial grimacing and screaming with transfer. Resident had pain with care. Resident was receiving x-ray and was grimacing and yelling when repositioned. Dr called and resident was transferred to hospital for further assessment.

The DOC confirmed the registered nursing staff training received training regarding pain management. [s. 52. (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 that ensures when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: 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 :

1. Review of Residents' Council Minutes, interview with the President and the members of the Residents' Council confirmed that the licensee did not respond to concerns in writing within 10 days of receipt from the Council. The review the Residents' Council meeting minutes for February 2014, January 2013, August 2013, September 2013, October 2013, and November 2013 confirmed the ongoing concerns identified in Residents' Council meeting regarding the food quality were not responded i.e. inconsistency of cooked vegetables (mushy, over cooked), food served on cold plates, hot food not hot enough and soggy food quality. [s. 57. (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 ensuring the licensee shall respond in writing within 10 days of receipt of concerns or recommendations from the Residents' Council, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.
On April 9, 11 and 14, 2014 the pureed meal served was not eye appealing. The texture of the pureed food was not dense and cohesive, rather runny on the plate. The instructions/direction provided by the home for heating puree food stated frozen/chilled pureed food to be heated on high heat in microwave for one and fifty seconds. However, in April, 2014 the dietary aide reported that the pureed food was thermalized in an "ISeco"heating cart and not in the microwave. Interview with the Food Service Supervisor confirmed that the "ISeco" heating cart was designed for retherming food in bulk quantities and not for the individualized puree food items. The dietary aide interviewed stated that the pureed food items were defrosted, cooked and held in "ISeco" heating cart for more than one hour before residents were served. The process used for retherming puree food i.e. food items held for an extended period of time in "ISeco" heating cart in advance of meal service resulted in reduced nutritive value, appearance and compromised food quality.
During the supper meal service the dietary aide was observed to be preparing puree soup. The staff person was noted adding 2 scoops of thickener product to hot minestrone soup in a blender. However, the instructions for preparing puree soup had directed the staff to add 4 OZ of hot soup and one slice of whole wheat bread per puree consistency and blend until smooth, portion and serve. The dietary aide interviewed stated the procedure and the written instructions for preparing puree soup were not followed, the thickener was added instead of bread to the puree soup. The directions for puree soup were not followed, resulting in soup consistency thick, lumpy and glossy, more of pudding consistency. [s. 72. (3) (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 ensuring that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #8: 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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. Nursing staff member indicated to inspector on April 17 that the resident did not necessarily require meal time supervision, which was contradictory to the resident's plan of care. [s. 73. (1) 4.]

2. The licensee did not ensure that the home's dining service includes monitoring of all residents during meals.

Lunch service to Resident #850 was observed on two occasions; breakfast service

was observed. During each observation, foods and fluids were brought into a resident's room and left there. The resident did not eat lunch during observations because they remained asleep; the foods and fluids remained in the room for 20 minutes and 26 minutes. PSW #3 confirmed the resident did not usually eat lunch and staff regularly left lunch in the resident's room. Staff did not enter or look into the room for 10 minutes during the breakfast observations and 20 minutes on a second observation. The resident's current plan of care specified that the resident must be visible to staff in dining room and was at risk of choking. On April 17, Nurse #2 stated the resident did not necessarily require meal time supervision, which was contradictory to the resident's plan of care. [s. 73. (1) 4.]

3. The licensee did not ensure that the food and fluids were served at a temperature that was both safe and palatable to the residents.
Foods were not served at a temperature that was both safe and palatable to the residents at the lunch meal. Food temperatures were taken just before the residents received meals. Pureed peas were 40 degree Celsius, Pureed Macaroni and cheese 50 degree Celsius. The MOH inspector spoke with the dietary aide, the food items were reheated before served to residents. The temperature monitoring record indicated that the foods were to be served above 140 degree Fahrenheit or 60 degree Celsius.
The supper meal service was observed. A PSW was noted to be serving regular soup from a black crock pot at approximately 1725 hours. The crockpot was sitting on a counter in the dining room. The soup was noted to be cool to touch. The dietary aide interviewed stated the minestrone soup was placed in the crockpot for reheating at approximately 1600 hour and that they were not aware the soup pot was broken. The minestrone soup was held in the crockpot with no heat for greater than one hour, and was probed at 10 degree Celsius. An improper hot holding/reheating temperature of hazardous food was noted, the soup temperatures were found to be in the unsafe temperature zone at the point of service. An unsafe holding and serving temperature of hazardous food not only causes potential for food contamination but also risk for food borne illness. [s. 73. (1) 6.]

4. The licensee had not ensured that sufficient time was allowed for every resident to eat at his or her pace. April 9, 2014 staff was observed removing meal plates when residents had not finished eating. The dietary staff was observed serving dessert at 1230 hours, residents served meal after 1215 were allowed less than 15 minutes to eat lunch, and not allowed sufficient time to eat at their pace. [s. 73. (1) 7.]

5. The licensee did not ensure that the home's dining service includes proper techniques to assist residents with eating, including safe positioning.

Resident #850 was observed lying flat in bed with the head of the bed not raised. Breakfast was delivered to the resident's room at 9:15am by Nurse #2 and left within the resident's reach for 10 minutes. The resident's current plan of care indicated that the resident was to maintain upright positioning and to avoid lying down, and for staff to ensure that the head of the bed was elevated. Nurse #2 confirmed that the head of the bed should be elevated for the resident at each meal. [s. 73. (1) 10.]

6. The licensee did not ensure that residents who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by the resident.
During an observed lunch meal, it was noted resident #000900 was not eating food served at 1215 hours. The plan of care had identified resident's eating ability impaired due to cognitive impairment, required extensive assistance, needed to be redirected and constant encouragement. The resident required significant cueing and encouragement was left unattended with no assistance for a period of greater than 15 minutes.

Residents #000901, #000902, #000903, and #000904 were observed who had not consumed their beverages, these residents required cueing and/or encouragement as specified in the plans of care. Staff did not make any attempts to encourage these residents to consume their fluids. Unconsumed fluids were removed from the tables. [s. 73. (2) (b)]

7. The licensee did not ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

During lunch observation, Residents #851, #852 and #853 received drinks at 12:18pm and food at 12:30pm. The residents did not receive assistance or encouragement until 12:35pm, 12:37pm and 12:43pm, respectively. As per the current plan of care, resident #851 was to receive total assistance at meals; the resident did not receive assistance for 17 minutes. Resident #852 was to receive supervision with intermittent assistance, with specific instructions not to put drinks in front of resident unless staff are present to assist or supervise; the resident did not receive assistance for 19 minutes after being served with fluids. Resident #853 was to receive constant

supervision as well as encouragement and coaxing due to a history of low intake at meals; the resident did not receive encouragement for 25 minutes after being served with fluids. Lunch observation Resident #853 was again not encouraged to consume foods or fluids until 12:31pm, 16 minutes after lunch service began. Staff interviews and reviews and interdepartmental documentation reviews confirmed that the staff were not to serve foods or fluids to residents requiring assistance until staff were available to assist the residents. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the food and fluids were served at a temperature that was both safe and palatable to the residents 73(1)(6); ensured that sufficient time was allowed for every resident to eat at his or her pace 73(1)(7);
ensuring that residents who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by the resident 73(2)(b);, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee of the home did not ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

The vanities in most resident bathrooms were not maintained. When observed the vanities were identified as being permanently stained and were damaged with melamine missing, cracked or peeling off. Housekeeping staff confirmed they are not able to get the stains off with cleaning.

The wooden handrails in most home areas where chipped, cracked, with ragged edges and gouges, which were unsafe for residents to hold. The Supervisor of Maintenance confirmed the handrails are not safe for residents.

The shower chair in the tub room in one home area had not been maintained. The chair was rusted on the bottom, sides and handle; and the mesh backing was hard and sagging.

The weight scales in the tub room in three home areas were rusted and soiled.

The toilet seat in a resident bathroom was chipped, ragged, and numerous scratches.

The water taps and faucet in a residents' bathroom was corroded.

The carpet in several rooms was worn, fraying with holes in three areas. The hallway of one home area had holes in the carpeting. [s. 90. (2) (d)]

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 that ensures that procedures are developed and implemented to ensure all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure home, furnishings and equipment are maintained in a safe condition and in a good state of repair.
Assistive feeding devices in use were not in good condition. Several melamine lipped plates found in three home areas were stained and had glaze worn off, exposing an absorbent inner liner thus creating risk of food contamination. [s. 15. (2) (c)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following are satisfied: 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

In April, 2014, on three separate occasions, Resident #04 was observed to be positioned in a tilt wheel chair.
Registered staff and PSW staff confirmed the resident was positioned in a tilt wheel chair for comfort and positioning.
On April 16, 2014 the OT confirmed that Resident #04 uses the tilt wheelchair as a PASD
Policy #19-03-02 Assessing for the Use of Personal Assistive Devices (PASD) requires use of the PASD has been consented to by the resident or substitute decision maker.
DOC confirmed this is current policy.
Review of the clinical records for Resident #04 revealed no consent from the resident or SDM for use of the PASD.
Registered staff confirmed the absence of consent from the resident or SDM for the PASD. [s. 33. (4) 4.]

WN #12: 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. A written response was not provided within 10 days of receiving Family Council advice related to concerns or recommendations. Interview with the Chair and the members of the Family Council confirmed that a written response was provided in the meeting minutes from the previous month meeting, however, not within 10 days of the actual Family Council meeting. [s. 60. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The license did not ensure the Director was informed no later than one business day after an occurrence of an incident. Resident #18 had a fall, were transferred to hospital and subsequently deceased. The Resident sustained a fracture from a fall. The critical incident was received 5 days after the fall. This was confirmed by the critical incident documentation and the Director of Care. [s. 107. (3)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

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

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2013_205129_0012	169
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2013_205129_0012	169

Issued on this 7th day of May, 2014

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

Yvonne Walton-Teael

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	YVONNE WALTON (169), ASHA SEHGAL (159), IRENE PASEL (510), KATHLEEN MILLAR (527), VIKTORIA SHIHAB (584)
Inspection No. / No de l'inspection :	2014_210169_0009
Log No. / Registre no:	H-000378-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 7, 2014
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF HALTON 1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1
LTC Home / Foyer de SLD :	ALLENDALE 185 ONTARIO STREET SOUTH, MILTON, ON, L9T-2M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHERYL RAYCRAFT

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To THE REGIONAL MUNICIPALITY OF HALTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:

1. the same level of quality is provided for all food items prepared for texture modified menu,
2. residents provided and served texture modified menu are offered a variety of fresh fruits and vegetables each day,
3. directions/instructions for all menu items including texture modified menu are available and followed in food preparation (rethermalization of frozen/cook chilled food),
4. the food appear appetizing to residents receiving texture modified menu
5. quality management activities (including the type of activities and frequency) and
6. staff education to be completed, including dates of the education.

The plan to be submitted by May 16, 2014, via Email to asha.sehgal@ontario.ca. LTC Homes Inspector, Ministry of Health and Long Term Care, 119 King Street west, 11 the Floor, Hamilton, ON L8P 4Y7

Grounds / Motifs :

1. The licensee did not ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. The pureed food served to resident was not visually appealing. The texture of the pureed food was too runny and created a risk for choking. At the lunch meal the texture of the pureed spinach and liver was thin and created risk for choking for residents

requiring thickened fluids. At the lunch pureed peas and macaroni and cheese were runny and not cohesive. The pureed food was not an appropriate consistency for residents requiring thickened fluids.

Not all residents were served foods that were nutritious and varied:
The pureed meat loaf served at lunch did not appear appetizing, a discoloured ring around the rim of the pureed meat was noted. The Food Service Supervisor confirmed that the planned pureed menu items i.e vegetables and entrees were precooked and out sourced. The pureed food items were defrosted, and heated in "ISeco heating cart" for more than an hour before served to residents resulted in reduced nutritive value and the appearance (discoloration of food).

The home's four week cycle menu offered to residents on puree diet was repetitious, did not provide variety of fresh seasonal foods each day from all food groups. Interviewed Food service supervisor and the dietary aide confirmed pureed texture menu did not provide similar choice, and variety of food items as for the regular menu. This was noted and confirmed by the dietary staff during the observed lunch and dinner meal service. The menu served to the residents on pureed diet did not include cold food items e.g. salads. The Villages of Halton pureed menu indicated week four the planned menu for Monday dinner is served pureed chicken noodle soup and pureed macaroni and cheese at the same meal on the same day, the Sunday planned lunch menu is served pureed lasagna and also for the dinner meal pureed spaghetti, the same food form i.e pasta x2 on the same day. Instant mashed potatoes are served to residents twice a day at lunch and dinner,there is a lack of variety for the meals.

A review of the Residents' Council and the Residents' Food Committee meeting minutes between January 2013 and March 2014 found ongoing concerns related to food quality. The issues and the comments identified were "mushy vegetables, soggy foods, sometime under cooked vegetables and hot food served cold." Residents interviewed reported and confirmed these ongoing issues related to food quality.
(159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 7th day of May, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : YVONNE WALTON

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