Ontario

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

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

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

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**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**

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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jul 12, 15, 18, 19, 20, 22, 25, 28, Aug 10, 11, Sep 23, 29, Oct 4, 5, 11, 18, 19, 24, Nov 7, 2011 | 2011_089115_0007 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BLENHEIM COMMUNITY VILLAGE
10 MARY AVENUE, P.O. BOX 220, BLENHEIM, ON, N0P-1A0

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

TERRI DALY (115), BONNIE MACDONALD (135), SANDRA FYSH (190), SHARON PERRY (155)

**Inspection Summary/Résumé de l'inspection**

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

**During the course of the inspection, the inspector(s) spoke with the Acting Executive Director, Director of Care, Environmental Services Manager, Office Manager, Dietary Manager, 4 Registered Nurses, 3 Registered Practical Nurses, 8 Personal Support Workers/Health Care Aides, 2 Housekeeping Aides, 4 Dietary Aides/Cooks, 1 Laundry Aide, 1 Recreation Aide, 1 Restorative Aide, 2 Regional Nursing Managers, 1 Provincial Food Services Manager, 40 residents and 3 family members.**

**During the course of the inspection, the inspector(s) conducted a tour of all resident areas and common areas, observed residents, observed the breakfast, lunch, and dinner meal services as well as snack service. Medication administration was observed and residents' clinical records were reviewed. The inspectors reviewed admission and resident charges records, policies and procedures pertaining to the inspection, as well as minutes of meetings related to the inspection.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**

**Accommodation Services - Laundry**

**Accommodation Services - Maintenance**

Revised for Publication

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Snack Observation

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 3. Residents' Bill of Rights**

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

**22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.**
**23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.**
**24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.**
**25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.**
**26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.**
**27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).**

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**Findings/Faits saillants :**

1. Resident's rights were not fully respected or promoted as observed during breakfast service when two residents were not provided with hot cereal until 9:34 a.m. and hot breakfast entrees until 9:48 a.m. Both residents had been in the dining room since 8:30 a.m., and waited 64 minutes before being served breakfast. They finished breakfast at 10:10 a.m., and both residents were back in the dining room at 12:00 p.m., for their lunch.
Dinner July 19, 2011 and breakfast and lunch, July 20, 2011, observed both residents were served last at meals.
[LTCHA, 2007 S.O. 2007, c.8,s. 3.(1) 4.]
2. A call bell was ringing in a resident bathroom. The resident was on the toilet and had rung for assistance. Call bell was not answered for approximately 12 minutes. Staff confirmed that the resident is not able to get on or off the toilet without 2 staff and use of mechanical lift. [LTCHA, 2007 S.O. 2007, c.8, s.3.(1) 4.]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**
**Specifically failed to comply with the following subsections:**

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

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

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met;**
**(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).**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. During a clinical record review for a high risk resident; it was observed the resident had not been reassessed, nor was the plan of care revised when care set out in the plan has not been effective.
During an interview with staff, they confirmed they no longer provide extra interventions.
During an interview with staff they stated there was no longer a need to monitor the resident. Staff confirmed they were not aware of the residents recent changes.
During an interview with staff it was confirmed that the resident's daily average intake was not acceptable as per resident's daily requirement.
[LTCHA, 2007 S.O. 2007, c.8, s. 6.(11)(b)]
2. During review of a residents progress note the home's Dietitian, wrote specific interventions to promote weight gain. Care set out in the plan was not provided to the resident during observations at the meal services.
[LTCHA, 2007 S.O. 2007, c.8, s. 6.(7)]
3. During a clinical record review for a resident, it was noted that the FIRM care plan expansion was not in place with the plan of care as per policy LTC-N-75 which states: " the FIRM care plan expansion will be initiated on admission when applicable and then become a source document for the development of the resident plan of care following the RAP review process".
A review of the plan of care noted that information for falls was initiated on January 14, 2010 and one area updated on June 29, 2010. The FIRM care plan expansion is not observed on the resident's chart.
During observation of a resident, it was noted that the resident's bed was not in the low and locked position as indicated on the plan of care.
During an interview with two staff it was confirmed that the FIRM care plan expansion is used for residents that have been identified as a risk for falls. [LTCHA, 2007 S.O.,c.8.s.6(7)]
4. During a review of a resident's clinical record the quarterly MDS assessments indicate that the resident is having moderate pain daily. A pain assessment inventory was not completed for this resident and the plan of care does not include a specific pain goal with interventions for relief of pain. Staff confirmed that a pain assessment inventory was not completed and the plan of care does not include a goal related to pain relief.
[LTCHA, 2007 S.O.,c.8.s.6(1)(c)]
5. During a review of resident a resident's clinical record, there is not a pain focus that describes the type of pain that the resident has, or specific interventions besides analgesics that may provide pain relief. [LTCHA, 2007 S.O.,c.8.s.6(1)(a),(b),(c)]
6. During a review of a resident's clinical record, there is not a specific pain focus on the plan of care to address the type, location, severity and pattern of the pain and the successful interventions besides analgesics for pain relief.
Staff providing care would benefit from knowing specific interventions that are successful in helping this resident achieve pain relief. [LTCHA, 2007 S.O.,c.8.s.6(1)(c)]
7. During a review of a resident's clinical records, the current care plan does not reflect the residents current status. [LTCHA, 2007 S.O.,c.8.s.6(10)(b)]
8. During an interview with staff it was indicated there is a need to up date the resident's care plan to reflect the residents current status and care needs. [LTCHA, 2007 S.O. 2007, c.8. s. 6. (1)(c)]
9. The plan of care for a resident does not identify individualized toileting times to reflect the needs of the resident. The plan indicates to toilet resident ac, pc meals and q hs. Staff indicate that they toilet the resident either before or after meals when needed. [LTCHA, 2007 S.O. 2007, c.8. s. 6. (1)(c)]
10. During observation of a resident, the call bell was not within reach. It was located on the opposite side of the room and would require the resident getting out of the chair and walking to the other side of the room to ring it. The plan of care states that the call bell should be within reach. [LTCHA, 2007 S.O.,c.8.s.6(7)]
11. The plan of care for a resident indicates that the resident requires one person assist for transfers but is independent with toileting. Staff confirmed that resident is incontinent and needs to be toileted by one staff.
Staff indicates that since the resident's health status has declined, the resident no longer transfers self and now requires 1-2 staff assist for transfers and toileting. There is no direction for staff in the plan of care as to when and how the resident is to be toileted. (115)
[LTCHA, 2007 S.O. 2007, c.8. s. 6. (1)(c)]

*Additional Required Actions:*

*CO # - 002, 008, 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".*

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following subsections:**

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(a) is a minimum of 21 days in duration;**
**(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;**
**(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;**
**(d) includes alternative beverage choices at meals and snacks;**
**(e) is approved by a registered dietitian who is a member of the staff of the home;**
**(f) is reviewed by the Residents' Council for the home; and**
**(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).**

**s. 71. (2) The licensee shall ensure that each menu,**
**(a) provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; and**
**(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).**

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**Findings/Faits saillants :**

1. During lunch service the served lunch menu did not provide for adequate nutrients, fibre and energy for residents based on the current Dietary Reference Intakes (DRI's) when the following portion sizes were observed as being smaller than the home's posted menu:
Vegetable salad served using #10 scoop, menu specifies #8 scoop required.
White rice served using #10 scoop, menu specifies # 8 scoop required.
Turkey Paprikash served using 3 oz. ladle, menu specifies # 8 scoop ( 4 oz.) required.
Diced carrots served using #12 scoop, menu specifies #8 scoop required.
During a review of the dinner food production with the late cook, observed the sweet and sour lamb did not provide adequate nutrients, fibre and energy when, 10 lbs. of lamb was used instead of the 14.5 lbs. as required by the recipe for 67 servings.
During an interview with staff, it was confirmed there was only 10 lbs., of lamb available for the sweet and sour lamb. [O.Reg 79/10, s. 71. (2) (a)]
2. Staff confirmed that the 4 week spring/summer menu cycle was completed July 22, 2011 and had not been reviewed with the home's Resident Council. This was confirmed during an interview with a Resident Council representative. [O.Reg 79/10, s. 71. (1) (f)]
3. During an interview with staff, it was confirmed that the home's spring/summer menu cycle that started June 20, 2011 had not been approved by the homes' Dietitian. [O.Reg 79/10, s. 71. (1) (e)]

*Additional Required Actions:*

*CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".*

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service;
(b) a cleaning schedule for all the equipment; and
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The home's Infection Control, Sanitation and Safety Cleaning schedule policy D-05-90, dated September 2004 was reviewed to determine compliance with the LTCHA and Regulations. The policy states the food service staff must initial the cleaning schedule after each cleaning is completed.
During review of the Dietary cleaning checklist for, the period July 1-18, 2011 the home has not complied with, the cleaning schedules for the food production, servery and dish washing areas as per the homes policy when the following cleaning schedules were not initialed staff for the period July 1-18, 2011:
Steam table had not been initialed as cleaned on 14 days, or 77.7 % of the time.
Grill-had not been initialed as cleaned on 13 days, or 72.2% of the time.
Fryer had not been initialed as cleaned on 17 days, or 94.4 % of the time.
Food processor had not been initialed as cleaned on 10 days, or 55.5 % of the time.
Kitchen floor had not been initialed as cleaned on 9 days, or 50 % of the time.
Toaster drawer to be cleaned weekly had not been initialed as cleaned in the month of July as of July 18, 2011.
During a review of cleaning schedules with staff, it was confirmed that the cleaning schedules had not been initialed by staff for the period July 1-18, 2011.
[O.Reg 79/10, s. 72. (7) (c)]
2. During review of food production records observed, menu substitutions were not documented on the production sheets as follows:
July 20, 2011, during review of breakfast production sheet, with staff, it was confirmed that the menu changes for cinnamon oatmeal and fruit yogurt had not been documented on the production sheets.
July 20, 2011, observed the following menu changes had not been documented on the production sheets, brown rice and broccoli salad. This was confirmed during an interview with staff.
During a review of the dinner production sheets, the chicken stir fry that was changed to sweet and sour lamb, had not been documented on the production sheets.
[O.Reg 79/10, s. 72. (2) (g)]
3. On July 19, 2011, during dinner service in Nursing Home dining room, observed there were no portion sizes posted on menu for puree or minced cabbage rolls for staff to reference.
During review of the recipe binder for correct portion sizes for dinner July 19, 2011, it was confirmed with staff that the following standardized recipes were not available for staff to reference for dinner service July 19, 2011:
Cabbage rolls, minced and puree cabbage rolls, Danish and puree Danish. [O.Reg 79/10, s. 72. (2) (c)]
4. On July 19, 2011, inspector observed in the refrigerated walk in storage unit, that not all fluids in the food production system were stored using methods to prevent adulteration, contamination and food borne illness when beverages had not been discarded after 48 hours as per the home's policy #FS-C-70, Handling of Leftovers, June 2007 which states; "all leftovers will be discarded after 48 hours":
On July 19, 2011, the inspector observed the following leftovers beverages in walk in refrigerator with dietary aide: honey thick 2% milk, and honey thick prune juice both dated July 12, 2011. Diet honey thick apple juice and honey thick orange juice, which were not dated.
During an interview with staff, it was confirmed that food or fluids left after service should be discarded after 48 hrs.
[O.Reg 79/10, s. 72. (3) (b)]
5. The Inspector observed the following menu substitutions were not communicated to residents prior to meal service:
On July 19, 2011, during lunch service in large Lodge dining room the following menu item substitutions for brown rice and broccoli were not communicated to residents. This was confirmed staff during lunch service.
On July 20, 2011, the inspector observed during breakfast service in the Nursing Home dining room the menu item substitutions for cinnamon oatmeal and fruit yogurt were not communicated to residents.
This was confirmed during an interview with staff.
[O.Reg 79/10, s. 72. (2) (f)]
6. On July 20, 2011, during the breakfast service in the Nursing Home dining room the inspector observed the following menu items were not prepared as per the home's planned menu:
cinnamon oatmeal, fruit yogurt and diet yogurt.
This was confirmed by a staff member.
During an interview with staff, it was confirmed that those menu items had not been sent.
During a review of the posted breakfast menu for residents, the inspector observed these menu changes had not been communicated to residents at breakfast service.
During an interview with staff it was confirmed that documentation on the production sheet of the menu substitutions for breakfast July 20, 2011 had not occurred.

7. On July 19, 2011, during lunch service in the large Lodge dining room the following menu items were not prepared as per the home's planned menu:
Brown rice, buttered brown bread, broccoli salad, minced and puree cranberry fruit salad, puree honey thick cantaloupe, puree ambrosia minced soup and puree honey thick lentil soup.
This was confirmed with two staff members.
On July 20, 2011, during the breakfast service in the small dining room, observed the following menu items were not prepared as per the home's planned menu: cinnamon oatmeal, fruit yogurt and diet yogurt.
During an interview with two staff it was confirmed that these menu items had not been sent or received.
O.Reg 79/10, s. 72. (2) (d)]
8. On July 20, 2011, during the walk-through of the kitchen, there were many pieces of equipment and machinery that needed to be cleaned. For example, the juice machine, garbage pails, carts that are used to transport items, centre island which includes the steam table (3 dry wells and 1 steam well).
The stove was very dirty with excessive debris built up on it. The floor was noted to be very dirty around all pieces of equipment.
There was a peanut butter jar on the counter beside the mixer, with a dirty radio placed on top of the peanut butter jar and leaning against the mixer.
Fridge and freezer temperatures were being completed, but there were temperatures noted that were out of the appropriate ranges and no action noted as being taken. [O. Reg. 79/10, s. 72 (7)]
9. On July 12, 2011 at the lunch meal in the Nursing Home dining room it was noted that a clear plastic container with a blue lid was not labeled contained a white powder substance and a white plastic spoon. Staff said that it was thickener. Spoon was left inside after use and substance had contact with handle of the spoon. [O. Reg. 79/10, s. 72 (3)(b)]
10. On July 12, 2011 at the lunch meal service in the Nursing Home dining room it was noted that a plastic container was not labeled or dated and contained buttered bread that had mold on it and an offensive odour was noted when opening the container. A plastic container that contained chocolate syrup was not labeled, not covered, nor dated and a build up of the syrup was noted on the outside of the container. [O. Reg. 79/10, s. 72 (3)(a)](115)

***Additional Required Actions:***

***CO # - 004, 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following subsections:**

**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:**
**1. Communication of the seven-day and daily menus to residents.**
**2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.**
**3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.**
**4. Monitoring of all residents during meals.**
**5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.**
**6. Food and fluids being served at a temperature that is both safe and palatable to the residents.**
**7. Sufficient time for every resident to eat at his or her own pace.**
**8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.**
**9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.**
**10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.**
**11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. During an interview with a representative of Resident's Council it was indicated that the resident's council does not have an opportunity to review the meal and snack times at their meetings. [O.Reg 79/10, s. 73(1)(2)]
2. On July 19, 2011, in the Nursing Home dining room observed dinner service for 23 residents. There were 19 residents (82.6%) who did not receive the correct food or fluid as per the home's Dining Servery Report. The following residents did not receive the correct food or fluid as per the Dining Servery Report, July 19, 2011:
A resident did not receive 125 mls. of chocolate milk. This was confirmed during an interview with resident.
A resident was served white bread. Dining Servery Report indicated resident to receive whole wheat bread.
A resident was not served 125 mls. of cranberry juice as per the Dining Servery Report.
The resident stated "likes to have it" when asked if the resident wanted cranberry juice with dinner.
A resident was not provided extra sauces or gravy for the main entrée, as per the Dining Servery Report.
A resident was not offered or provided vanilla pudding as per the Dining Servery report.
[O.Reg 79/10, s. 73 (1) 5.]
3. The inspector observed at breakfast service that the dining table was not at an appropriate height for a resident, when the resident was observed eating breakfast from her lap. This was reviewed with a staff member who agreed that they should look at other options for the resident.
The inspector observed at dinner service that the dining table was not at the appropriate height for a resident, when the resident was observed eating the meal at chin level with table height and the resident was reaching up to eat dinner.
[O.Reg 79/10, s. 73 (1) 11.]
4. The inspector observed p.m. snack service for 42 residents. There were 13 residents (30.2%) who did not receive the correct snack or beverage as per the home's Snack Delivery Report and their plans of care.
Staff confirmed that errors had been made.
During another p.m. snack service five residents did not receive the correct snack or beverage as per their nutritional plans of care.
[O.Reg 79/10, s. 73 (1) 5.]
5. The inspector observed a residents p.m. ice cream snack was not palatable as it was melted when it was served.
During an interview with staff, it was confirmed that the resident does not prefer the ice cream melted.
Snack service began at 2:42 p.m., and at 3:50 p.m., the ice cream had melted as there was no method of keeping the ice cream cold during service. [O.Reg 79/10, s. 73 (1) 6.]

***Additional Required Actions:***

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

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums**

**Specifically failed to comply with the following subsections:**

**s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,**
**(a) the preparation of resident meals and snacks;**
**(b) the distribution and service of resident meals;**
**(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and**
**(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).**

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**Findings/Faits saillants :**

1. Inspector observed the home's food services department presently does not have sufficient food service worker hours each week to perform all food service functions for resident and non- resident meals as evidenced by the following:

During a staff interview the home's financial records were reviewed since March 2011, for the number of meals provided for residents and non residents; i.e. nursing home, lodge, Meals On Wheels and visitor meals. It was determined from those records the home has a requirement for, 318.81 food service worker hours/week.

During a staff interview it was confirmed the actual weekly total worked food service hours for food preparation, service, distribution, cleaning and sanitizing of equipment and work areas is 258.5 hours/week for resident and non resident meals.

***Additional Required Actions:***

***CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**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).**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.**
**2. Residents must be offered immunization against influenza at the appropriate time each year.**
**3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.**
**4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.**
**5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).**

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**Findings/Faits saillants :**

1. A review of 4 recently admitted resident's clinical records indicate that they do not have documentation of being offered immunizations against tetanus and diptheria.
[O.Reg 79/10,s.229.(10)(3)]
2. Staff do not participate in the homes infection control program as evidenced by:
a) A staff member was observed walking up the hall with gloves on, that staff removed 2 Accel wipes, then returned down the hall, wiped the lift with the wipes, then entered a residents room with same gloves on.
b) A review of the homes Infection Control policies was conducted. Policy LTC-I-120 directs staff to remove gloves and discard immediately on leaving a resident's room.
c) A staff member exited a resident's room and sorted through various areas on the linen cart, looking for items, then removed and discarded gloves that had been used.
d) A staff member was observed exiting a resident room and walking down Sunshine (Hall 1) wearing gloves, the staff then went into a resident room which is a contact isolation room and conversed with the other staff in that room. The staff then exited that room and came back down the hall in front of the nursing station and removed the gloves.
e) At a lunch meal service handwashing/sanitizing was not observed after a staff member served the lunch meal and then fed the residents. Three staff were also observed clearing soup bowls and cups from tables and then returning to feed residents their main course without any hand washing or any use of hand sanitizer. A staff member was observed clearing dishes and then returned to the steam cart and dished out 3 bowls of soup without any hand washing or use of hand sanitizer.
Prior to the staff member packing up the items from the steam table the staff member washed hands using water but no soap used.(155)(115)
f) A staff member was observed blowing on each spoonful of a resident's soup prior to feeding it to her.
A staff member was also observed moving from one resident to another during lunch to assist with their meal picking up sandwiches and handing to residents, without hand-washing or hand hygiene in between.(155)
g) Three staff were observed in the dining room at the breakfast meal service wearing hairnets inappropriately. The hairnets did not cover hair completely and hair was hanging out under the hairnets.
[O.Reg 79/10,s.229.(4)]
3. During a review of the Infection Control meeting minutes from April 19, 2011, a rise in wound and urinary tract infections was noted and a "sub-committee meeting" has not occurred in order to address these increases as per policy LTC-I-120. (190) [O.Reg 79/10,s.229.(2)(a)]

***Additional Required Actions:***

***CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there that all staff participate in the program, that immunization and screening measures are in place in relation to tetanus and diptheria, and that there is an interdisciplinary team approach in coordination and implementation of the program, to be implemented voluntarily.***

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**WN #8: 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 subsections:**

**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;**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and**
**(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).**

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**Findings/Faits saillants :**

1. The inspector observed the following main kitchen areas and food service equipment were not clean and sanitary:
-Build up of food debris on floors under kitchen counters, convection and conventional ovens and steamer and floor at exit door at rear of kitchen.
-Toaster crumb tray had large build up of blackened toast crumbs.
-Build up of grease and food spatter was observed on fryer, grill top and walls behind this equipment.
-Light over cart loaded with clean dishes had dust hanging from the light.
-In dish room the exhaust hood had build up of dust in the exhaust fan, and bin used to transport dirty dishes was black with mould growth. Lower wall under dirty end of dish machine had mould growth along the coving between floor and wall area.
During a walk through of the main kitchen with staff, it was confirmed these work areas and equipment were not clean and sanitary.
[LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) (a)]
2. It was observed that generally, the chairs and tables in common areas, including the legs and corners are in need of touch up, cover over baseboard heater in tub room room #205 is falling off and heat is on.
Corners of walls and door frames are heavily chipped. Wall damage is evident and paint is peeling off
Chairs in hallways and in the lounges observed with chipped legs, and the finish coming off legs.
3. It is noted that edges along baseboards have significant build-up of dirt.
4. It was observed that a large artificial tree in the large Lodge dining room was covered in dust.
Dirt was noted to be built up along the edges of the walls under the baseboards.
5. At the lunch meal service in Nursing Home dining room it was noted that the sink drain had a buildup of a black substance; ants noted on the counter top by sink; steam cart well had dirty water with food debris floating in it; the steam cart between cutting board and stainless steel had a large amount of crumbs/food debris; a plastic container on counter containing buttered bread that was moldy was not dated or labeled; and the base of the cupboards had a buildup of a dirt and a black substance along them.
[LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(a)(c)] (115)

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is an organized program for housekeeping and maintenance in the home, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.**

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**Findings/Faits saillants :**

1. During a staff interview with inspector #135, it was confirmed that the Quality Improvement program policy CQI-H-10, January 2008 Calendar of CQI Activities, that following have not been implemented as per the home's schedule:
-MBWA (Management by Walking Around) to be done daily has not been completed
-Meal Service/Temperature Audits to be done weekly has not been completed.
-Temperature/Chemical Audit to be done weekly has not been completed.
-Sanitation Audit to be done monthly has not been completed.
-Diet Order/Meal Audit to be done monthly has not been completed.
-Plate Audit to be done quarterly has not been completed.

During a staff interview with staff it was confirmed that the following Quality Improvement program policy CQI-E-10 Sept. 2007 and CQI-G-10 May 2007, the Calendar of CQI Activities have not been completed per schedule:
-MBWA to be done daily has not been completed

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home implements planned quality improvement measures, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following subsections:**

**s. 85. (2) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly. 2007, c. 8, s. 85. (2).**

**s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**s. 85. (4) The licensee shall ensure that,**
**(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3);**
**(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;**
**(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and**
**(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).**

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**Findings/Faits saillants :**

1. During an interview with a representative of Resident's Council it was indicated that the council has not seen the results of the 2010 satisfaction survey. [LTCHA, 2007 S.O., c.8,s.85(4)(a)]
2. During an interview with a representative of the Resident's Council, it was indicated that the home does not seek the advice of the Resident's Council in developing and carrying out the satisfaction survey, or in acting on its results. [LTCHA, 2007 S.O., c.8,s.85(3)]
During an interview with staff, it was confirmed that currently the Resident's Council is not involved in helping develop or carry out the satisfaction survey. [LTCHA, 2007 S.O., c.8,s.85(3)] ( 115)
3. During a staff interview it was indicated that the documents setting out the survey results and actions taken to improve the home were not available during this inspection. [LTCHA, 2007 S.O., c.8,s.85(4)(d)]
4. During a staff interview it was indicated that the survey results of the 2010 satisfaction survey have not been made available to residents and their families. [LTCHA, 2007 S.O., c.8,s.85(4)(c)]
5. During a staff interview it was indicated that actions taken to improve the home based on the results of the 2010 satisfaction survey are not documented and have not been made available to the Residents' Council.
A review of the Residents' Council Meeting Minutes from 2010 do not indicate an action plan implemented to improve the home based on the 2010 Satisfaction Survey results. [LTCHA, 2007 S.O., c.8,s.85(4)(b)]
6. During a staff interview it was indicated that the documented results of the satisfaction survey from 2010 have not been made available to the Residents' Council for their advice.
A review of the Residents' Council Meeting Minutes from 2010 do not indicate a review of the 2010 Satisfaction Survey results. [LTCHA, 2007 S.O., c.8,s.85(4)(a)]
7. During a staff interview the home could not provide or re-call the implementation of an action plan for the results of the 2010 satisfaction survey. [LTCHA, 2007 S.O., c.8,s.85(2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure satisfaction survey development, results and actions are made available, and advice sought for improvements by Residents' and Family Council, to be implemented voluntarily.***

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**WN #11: 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 subsections:**

**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).**

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**Findings/Faits saillants :**

1. During a tour of the home, it was noted that the raised garden/flowerbeds outside the nursing home dining room in the Gardenview hall that have not been tended at all. It is full of weeds and is unsightly from the dining room windows.
The entrances to the home have not been maintained as per the policy as evidenced by empty flower urns that have garbage in them, dirt and debris including soiled kleenex's at the Administrative office entrance to the home.
[O.Reg 79/10, s. 8.(1)(b)]
2. Policy LTC-N-110 states that the "Backyard Gardens/Indoor Plants" program will support the home's ALIVE program. The leadership and partnership team will oversee the activities and will establish a partnership with the local horticultural society and involve the resident's. [O.Reg 79/10, s. 8.(1)(b)]
3. During a review of the homes pain program, policy LTC-N-50 states that causes and risk factors for pain will be identified and managed. The Plan of Care will outline interventions to be utilized and expected outcomes and will reflect the Resident's goals/needs. [O.Reg 79/10, s. 8.(1)(b)]
During a review of a resident clinical record the causes and risk factors for pain are not identified on the plan of care. The expected outcomes are also not reflected in the goals/needs. [O.Reg 79/10, s. 8.(1)(b)]
4. During a review of the home's fall program, policy LTC-N-75 states that the "FIRM" - Fall Interventions Risk Management care plan expansion will be used on admission where applicable and then become a source document for the development of the Resident Plan of Care following the RAP review process.
The "FIRM" care plan expansion was not used on the clinical records of a resident [O.Reg 79/10, s. 8.(1)(b)]
5. During a review of Policy LTC-G-30-ON/BC titled Delegation of Function for Application of Topical Treatments, Creams, Ointments and Shampoos states that the DOC and/or designated Registered staff will review the procedure for application of topical treatment with the identified UPC during orientation, annually and as required, and document that the UCP has received the educational instruction. Five UCPs have not been trained in the procedure for the application of topical medications. It was confirmed by staff that the UCPs still apply topical medications even though they have not had the educational instruction. [O,Reg 79/10, 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 to ensure policies are implemented, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following subsections:**

**s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,**
**(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals;**
**(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and**
**(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).**

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**Findings/Faits saillants :**

1. During the review of the application of treatment creams and lotions by front line staff, it was noted that staff that did not receive the education, still apply topical medications. Staff confirmed that topical medication is administered even though all staff have not been trained.
[O.Reg 79/10, s.131(4)(a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that registered staff permitting staff members to administer a topical medication are supervised, trained, and the registered staff member is satisfied that the topical medication is administered safely, to be implemented voluntarily.***

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

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**Findings/Faits saillants :**

1. A review 6 resident's clinical records indicates that a current, signed quarterly drug review has not been completed, or has not been completed in a timely manner.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a quarterly review is completed and documented for each resident's drug regime, to be implemented voluntarily.***

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**WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

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**Findings/Faits saillants :**

1. A staff member was observed spray buffing the hallway with a swing burnisher/polisher and spray. Staff was observed swinging the buffer from side to side across the hallway. The inspector stood behind waiting to pass along the right side of the hallway. The staff then began to polish only one side of the hall. Once the inspector returned the staff member, was noted to again swing the polisher side to side across the entire hallway again, preventing residents from being able to pass. (190)
Two staff confirmed that the expectation when polishing or burnishing a hallway, would be to complete one side at a time, allowing residents, visitors and staff to pass on the opposite side safely.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is safe for all residents when staff are polishing floors, to be implemented voluntarily.***

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program**

**Specifically failed to comply with the following subsections:**

**s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,**
**(a) the provision of supplies and appropriate equipment for the program;**
**(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;**
**(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests;**
**(d) opportunities for resident and family input into the development and scheduling of recreation and social activities;**
**(e) the provision of information to residents about community activities that may be of interest to them; and**
**(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).**

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**Findings/Faits saillants :**

1. A review of activity schedules for 3 residents for the past six months indicates that there are no activities for residents every other Saturday and the same activity occurs every Sunday (a movie in the activity room) at 2:00 p.m. [O.Reg 79/10, s. 65.(2)(b)]
During a resident interview by inspector #115, the resident indicated that no activities are offered on weekends and no activities are available in the evenings.
During a resident interview by inspector #155, the resident indicated that no activities are available in the evenings. [O.Reg 79/10, s. 65.(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 to ensure the development, implementation and communication of recreation and social activities offered during days, evenings and weekends, to be implemented voluntarily.***

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following subsections:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(a) cleaning of the home, including,**
**(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and**
**(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;**
**(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:**
**(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,**
**(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and**
**(iii) contact surfaces;**
**(c) removal and safe disposal of dry and wet garbage; and**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. During observation of the tubroom it was noted that upon entrance into the room a stale offensive odour was evident, and used briefs were observed in an uncovered waste basket.
(135)

It has been noted by all inspectors that throughout the inspection on a daily basis a lingering offensive odour is noted upon entrance of the building known at the Administrative entrance and while conducting our inspection in the long term care area of the home, mainly hall 2. (190) (155) (135)
[O.Reg. 79/10, s.87(2)(d)]
2. Information was collected during a family interview with inspector #190, about the Building/Environment being uncomfortable.

When the family member was asked if the building was a comfortable building in which to live, the family member responded "No, the building frequently has an odour noted."

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing lingering offensive odours, to be implemented voluntarily.***

**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

**Specifically failed to comply with the following subsections:**

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**
**(a) procedures are developed and implemented to ensure that,**
**(i) residents' linens are changed at least once a week and more often as needed,**
**(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
**(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
**(iv) there is a process to report and locate residents' lost clothing and personal items;**
**(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;**
**(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and**
**(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

1. During a tour of the laundry room, staff confirmed that there is a system in place to ensure that linens that are stained or torn are removed from the system.
During a tour and observation the linens in the tub room were found in poor conditions - bath "hoodies" were thread-bare; 3 face-cloths were yellowed; 5 bath towels were thin and thread-bare.
Bath hoodies, bath towels, and face clothes noted to be thin, discolored and show signs of wear.
[O.Reg. 79/10, s.89(1)(c)]

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following subsections:**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;**
**(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;**
**(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;**
**(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;**
**(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;**
**(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;**
**(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;**
**(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;**
**(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;**
**(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and**
**(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).**

**Findings/Faits saillants :**

1. A system is in place for recording water temperatures at source.
However, on July 4, 5, and 6, 2011 no temperatures were recorded.
On June 2 and 26, 2011 no temperatures were recorded.
On May 27, 28, 29 and 30, 2011 no temperatures were recorded
On May 2, 3, 7, 8 and 11, 2011 temperatures of 50 degrees were recorded with no action to address.
On April 7, 8, 10, 14, 22 and 28, 2011 no source temperatures were recorded.
On April 4, 5, 6, and 9, 2011 temperatures of 50 degrees were recorded with no action to address.
[O.Reg. 79/10, s.90(2)(h)]

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following subsections:**

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

**Findings/Faits saillants :**

1. During a review of a resident's clinical records, there were no notes made regarding pain or range of motion as per policy LTC N-75 -Resident Fall Documentation.
Staff confirmed that the home uses the Resident Fall Documentation sheet as a guide for documentation in point click care and should include pain and range of motion assessment.

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**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following subsections:**

**s. 52. (1) The pain management program must, at a minimum, provide for the following:**
**1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.**
**2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.**
**3. Comfort care measures.**
**4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).**

**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. During a review of a resident's clinical records, a pain assessment inventory was not completed to further explore contributing factors, patterns of pain episodes and responses to previous interventions.
2. During a review of a resident's clinical records, there is not a specific pain focus to address the type, location, severity and pattern of the pain and the successful interventions besides analgesics for pain relief.

*Additional Required Actions:*

*VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a pain management program is in place that includes pain assessment, strategies to manage pain, and ongoing monitoring, to be implemented voluntarily.*

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**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.**

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**Findings/Faits saillants :**

1. During an interview with a resident, it was indicated that the resident does not sleep well during the night and staff go in and get the resident up at 6 a.m. A review of the plan of care does not identify the resident's desired bedtime and rest routines. Interview with staff confirmed that the desired bedtimes and rest routines are not on the plan of care. Staff indicated that the resident will tell them if [redacted] wants to remain in bed to rest.
2. During an interview with a resident, it was indicated that the resident would like to stay in bed later some days. The resident states that staff go in between 6:30-7:00 a.m. to get the resident up. Interview with staff confirmed that the desired rest routines are not on the plan of care. Staff indicated that the resident will tell them when they wake[redacted] up if [redacted] wants to rest.

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**WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

**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)**

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**Findings/Faits saillants :**

1. During a review of the home's admission process it was noted that there was no explanation of the evacuation procedures posted. On the plaque above the required postings that are in a binder it listed that the evacuation procedure was included. Upon review it was not in the binder. Staff confirmed that the evacuation procedure was not posted in the binder.
[LTCHA, 2007, S.O. 2007, c.8, s.79.(3)(j)]

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**WN #23: 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 (1) 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)**

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**Findings/Faits saillants :**

1. During a review of the admission package it was noted that the package did not include an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to resident. An Interview with staff confirmed that this was not included. [LTCHA, 2007 S.O. 2007, c.8, s. 78 (2)(d)]
2. During a review of the admission package the Blenheim Community Village Resident Information Handbook was reviewed and it does not contain the home's mission statement, only the Corporate mission statement is included. An interview with staff confirmed that the home's mission statement was not included. [LTCHA, 2007 S.O. 2007, c.8, s. 78 (2)(b)]

Issued on this 16th day of November, 2011

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

Jerri Daly

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) :** | TERRI DALY (115), BONNIE MACDONALD (135), SANDRA FYSH (190), SHARON PERRY (155) |
| **Inspection No. / No de l'inspection :** | 2011_089115_0007 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Date of Inspection / Date de l'inspection :** | Jul 12, 15, 18, 19, 20, 22, 25, 28, Aug 10, 11, Sep 23, 29, Oct 4, 5, 11, 18, 19, 24, Nov 7, 2011 |
| **Licensee / Titulaire de permis :** | REVERA LONG TERM CARE INC.<br>55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2 |
| **LTC Home / Foyer de SLD :** | BLENHEIM COMMUNITY VILLAGE<br>10 MARY AVENUE, P.O. BOX 220, BLENHEIM, ON, N0P-1A0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | ~~Barb Ferren.~~ GWEN DALY |

To REVERA LONG TERM CARE INC., 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

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**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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007. S.O. 2007, c. 8, s. 3. (1). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. A call bell was ringing in a resident bathroom. The resident was on the toilet and had rung for assistance. Call bell was not answered for approximately 12 minutes. Staff confirmed that the resident is not able to get on or off the toilet without 2 staff and use of mechanical lift.
[LTCHA, 2007 S.O. 2007, c.8,s. 3.(1) 4.] (155)
2. Resident's rights were not fully respected or promoted as observed during breakfast service when two residents were not provided with hot cereal until 9:34 a.m. and hot breakfast entrees until 9:48 a.m. Both residents had been in the dining room since 8:30 a.m., and waited 64 minutes before being served breakfast. They finished breakfast at 10:10 a.m., and both residents were back in the dining room at 12:00 p.m., for their lunch.
Dinner July 19, 2011 and breakfast and lunch, July 20, 2011, observed both residents were served last at meals.
[LTCHA, 2007 S.O. 2007, c.8,s. 3.(1) 4.] (135)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 09, 2011

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**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007. S.O. 2007, c. 8, s. 6. (1). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. The plan of care for a resident does not identify individualized toileting times to reflect the needs of the resident. The plan indicates to toilet resident ac, pc meals and q hs. Staff indicate that they toilet the resident either before or after meals when needed.
[LTCHA, 2007 S.O. 2007, c.8. s. 6. (1)(c)] (155)
2. During an interview with staff the need to up date the resident's care plan to reflect the residents current status and care needs was indicated.
[LTCHA, 2007 S.O. 2007, c.8. s. 6. (1)(c)] (115)
3. During an interview with staff the need to up date the resident's care plan to reflect the residents current status and care needs was indicated.
[LTCHA, 2007 S.O.,c.8.s.6(1)(c)] (115)
4. During a review of a resident's clinical record, there is not a specific pain focus on the plan of care to address the type, location, severity and pattern of the pain and the successful interventions besides analgesics for pain relief.
Staff providing care would benefit from knowing specific interventions that are successful in helping this resident achieve pain relief.
[LTCHA, 2007 S.O.,c.8.s.6(1)(c)] (190)
5. During a review of a resident's clinical record, there is not a pain focus that describes the type of pain that the resident has, or specific interventions besides analgesics that may provide pain relief.
[LTCHA, 2007 S.O.,c.8.s.6(1)(c)] (190)
6. During a review of a resident's clinical record the quarterly MDS assessments indicate that the resident is having moderate pain daily. A pain assessment inventory was not completed for this resident and the plan of care does not include a specific pain goal with interventions for relief of pain. Staff confirmed that a pain assessment inventory was not completed and the plan of care does not include a goal related to pain relief.
[LTCHA, 2007 S.O.,c.8.s.6(1)(b)] (190)
7. During a clinical record review for a resident, it was noted that the FIRM care plan expansion was not in place with the plan of care as per policy LTC-N-75 which states: " the FIRM care plan expansion will be initiated on admission when applicable and then become a source document for the development of the resident plan of care following the RAP review process".
During review of the plan of care it was noted that information for falls was initiated on January 14, 2010 and one area updated on June 29, 2010. The FIRM care plan expansion is not observed on the resident's chart.
During observation of a resident, it was noted that the resident's bed was not in the low and locked position as indicated on the plan of care.
During an interview with staff it was confirmed that the FIRM care plan expansion is used for residents that have been identified as a risk for falls.
[LTCHA, 2007 S.O.,c.8.s.6(1)(c)] (190)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 09, 2011

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

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**Order # / Ordre no :** 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.71 (1). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. During a staff interview it was confirmed that the home's spring/summer menu cycle that started June 20, 2011 had not been approved by the homes' Dietitian.
[O.Reg 79/10, s. 71. (1) (e)] (135)
2. Staff confirmed that the 4 week spring/summer menu cycle was completed July 22, 2011 and had not been reviewed with the home's Resident Council. This was confirmed during an interview with a Resident Council representative.
[O.Reg 79/10, s. 71. (1) (f)] (135)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Dec 09, 2011

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**Order # / Ordre no :** 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.72 (2). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. On July 19, 2011, during lunch service in the large Lodge dining room the following menu items were not prepared as per the home's planned menu:
Brown rice, buttered brown bread, broccoli salad, minced and puree cranberry fruit salad, puree honey thick cantaloupe, puree ambrosia minced soup and puree honey thick lentil soup.
This was confirmed by two staff members.
On July 20, 2011, during the breakfast service in the small dining room, observed the following menu items were not prepared as per the home's planned menu: cinnamon oatmeal, fruit yogurt and diet yogurt.
This was confirmed by two staff members.
[O.Reg 79/10, s. 72. (2) (d)] (135)
2. On July 20, 2011, during the breakfast service in the Nursing Home dining room the inspector observed the following menu items were not prepared as per the home's planned menu:
cinnamon oatmeal, fruit yogurt and diet yogurt.
This was confirmed by a staff member.
During an interview with staff it was confirmed these menu items had not been sent.
During a review of the posted breakfast menu for residents, the inspector observed these menu changes had not been communicated to residents at breakfast service.
During an interview with staff it was confirmed that documentation on the production sheet of the menu substitutions for breakfast July 20, 2011 had not occurred. (135)
3. The Inspector observed the following menu substitutions were not communicated to residents prior to meal service:
On July 19, 2011, during lunch service in large Lodge dining room the following menu item substitutions for brown rice and broccoli were not communicated to residents. This was confirmed by staff during lunch service.
On July 20, 2011, the inspector observed during breakfast service in the Nursing Home dining room the menu item substitutions for cinnamon oatmeal and fruit yogurt were not communicated to residents.
During an interview with two staff this was confirmed.
[O.Reg 79/10, s. 72. (2) (f)] (135)
4. On July 19, 2011, during dinner service in Nursing Home dining room, observed there were no portion sizes posted on menu for puree or minced cabbage rolls for staff to reference.
During review of the recipe binder for correct portion sizes for dinner July 19, 2011, it was confirmed with staff that the following standardized recipes were not available for staff to reference for dinner service July 19, 2011: Cabbage rolls, minced and puree cabbage rolls, Danish and puree Danish.
[O.Reg 79/10, s. 72. (2) (c)] (135)
5. During review of food production records observed, menu substitutions were not documented on the production sheets as follows:
July 20, 2011, during review of the breakfast production sheet, staff confirmed the menu changes for cinnamon oatmeal and fruit yogurt had not been documented on the production sheets.
July 20, 2011, observed the following menu changes had not been documented on the production sheets, brown rice and broccoli salad. This was confirmed during an interview with staff.
During a review of the dinner production sheets, the chicken stir fry that was changed to sweet and sour lamb, had not been documented on the production sheets.
O.Reg 79/10, s. 72. (2) (g)] (135)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 09, 2011

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**Order # /**
**Ordre no :** 005

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.73 (1). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. The inspector observed a residents p.m. ice cream snack was not palatable as it was melted when it was served.
During an interview with a staff member it was confirmed that the resident does not prefer the ice cream melted.
Snack service began at 2:42 p.m., and at 3:50 p.m., the ice cream had melted as there was no method of keeping the ice cream cold during service.
[O.Reg 79/10, s. 73 (1) 6.] (135)
2. The inspector observed p.m. snack service for 42 residents. There were 13 residents (30.2%) who did not receive the correct snack or beverage as per the home's Snack Delivery Report and their plans of care.
Staff confirmed that errors had been made.
During another p.m. snack service five residents did not receive the correct snack or beverage as per their nutritional plans of care.
[O.Reg 79/10, s. 73 (1) 5.] (135)
3. The inspector observed at breakfast service that the dining table was not at an appropriate height for a resident, when the resident was observed eating breakfast from their lap. This was reviewed with staff, who agreed that they should look at other options for the resident.
The inspector observed at dinner service that the dining table was not at the appropriate height for another resident, when the resident was observed eating the meal at chin level with table height and the resident was reaching up to eat dinner.
[O.Reg 79/10, s. 73 (1) 11.] (135)
4. On July 19, 2011, in the Nursing Home dining room observed dinner service for 23 residents. There were 19 residents (82.6%) who did not receive the correct food or fluid as per the home's Dining Servery Report. The following residents did not receive the correct food or fluid as per the Dining Servery Report, July 19, 2011:
A resident did not receive 125 mls. of chocolate milk. This was confirmed during an interview with resident.
A resident was served white bread. Dining Servery Report indicated resident to receive whole wheat bread.
A resident was not served 125 mls. of cranberry juice as per the Dining Servery Report.
The resident stated "likes to have it" when asked if the resident wanted cranberry juice with dinner.
A resident was not provided extra sauces or gravy for the main entrée, as per the Dining Servery Report.
A resident was not offered or provided vanilla pudding as per the Dining Servery report.
[O.Reg 79/10, s. 73 (1) 5.] (135)
5. During an interview with a representative of the Resident's Council it was indicated that the resident's council does not have an opportunity to review the meal and snack times at their meetings.
[O.Reg 79/10, s. 73 (1) 2.] (190)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 09, 2011

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

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**Order # / Ordre no :** 006

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks;
(b) the distribution and service of resident meals;
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.77 (1). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. Inspector observed the home's food services department presently does not have sufficient food service worker hours each week to perform all food service functions for resident and non- resident meals as evidenced by the following:
During a staff interview the homes' financial records were reviewed since March 2011, for the number of meals provided for residents and non residents; i.e. nursing home, lodge, Meals On Wheels and visitor meals. It was determined from those records the home has a requirement for, 318.81 food service worker hours/week.
During a staff interview it was confirmed the actual weekly total worked food service hours for food preparation, service, distribution, cleaning and sanitizing of equipment and work areas is 258.5 hours/week for resident and non resident meals.

[O. Reg. 79/10, s. 77 (1)] (135)

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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**

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**Order # / Ordre no :** 007

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.229 (4). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. Three staff were observed in the dining room at the breakfast meal service wearing hairnets inappropriately. The hairnets did not cover hair completely and hair was hanging out under the hairnets.
[O.Reg 79/10,s.229.(4] (190)
2. At a lunch meal service handwashing/sanitizing was not observed after a staff member served the lunch meal and then fed the residents. Three staff were also observed clearing soup bowls and cups from tables and then returning to feed residents their main course without any hand washing or any use of hand sanitizer. A staff member was observed clearing dishes and then returned to the steam cart and dished out 3 bowls of soup without any hand washing or use of hand sanitizer.
Prior to the staff member packing up the items from the steam table the staff member washed hands using water but no soap used.(155)(115)
[O.Reg 79/10,s.229.(4] (155)
3. A staff member was observed blowing on each spoonful of a resident's soup prior to feeding it to her.
A staff member was also observed moving from one resident to another during lunch to assist with their meal picking up sandwiches and handing to residents, without hand-washing or hand hygiene in between.
[O.Reg 79/10,s.229.(4] (190)
4. A staff member was observed exiting a resident room and walking down Sunshine (Hall 1) wearing gloves, the staff then went into a resident room which is a contact isolation room and conversed with the other staff in that room. The staff then exited that room and came back down the hall in front of the nursing station and removed the gloves.
[O.Reg 79/10,s.229.(4] (190)
5. A staff member exited a resident's room and sorted through various areas on the linen cart, looking for items, then removed and discarded gloves that had been used.
[O.Reg 79/10,s.229.(4] (190)
6. A review of the homes Infection Control policies, policy LTC-I-120 directs staff to remove gloves and discard immediately on leaving a resident's room.
[O.Reg 79/10,s.229.(4] (190)
7. A staff member was observed walking up the hall with gloves on, that staff removed 2 Accel wipes, then returned down the hall, wiped the lift with the wipes, then entered a residents room with same gloves on.
[O.Reg 79/10,s.229.(4] (190)

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Ontario

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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**

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**Order # / Ordre no :** 008

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.77 (1). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. During a clinical record review for a high risk resident; it was observed the resident had not been reassessed, nor was the plan of care revised when care set out in the plan has not been effective.
During an interview with staff, they confirmed they no longer provide extra interventions.
During an interview with staff they stated there was no longer a need to monitor the resident. Staff confirmed they were not aware of the residents recent changes.
During an interview with staff it was confirmed that the resident's daily average intake was not acceptable as per resident's daily requirement.
[LTCHA, 2007 S.O. 2007,c.8,s.6.(11)(b)] (135)

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**Order # / Ordre no :** 009

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.77 (1). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. During observation of a resident , the call bell was not within reach. It was located on the opposite side of the room and would require the resident getting out of the chair and walking to the other side of the room to ring it. The plan of care states that the call bell should be within reach.
[LTCHA, 2007 S.O.,c.8.s.6 (7)] (190)
2. During observation of a resident it was noted that the resident's bed was not in the low and locked position as indicated on the plan of care. (190)
3. During review of a residents progress note the home's Dietitian, wrote specific interventions to promote weight gain. Care set out in the plan was not provided to the resident during observations at the meal services.
[LTCHA, 2007 S.O. 2007, c.8, s. 6. (7)] (135)

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Ontario

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

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**Order # / Ordre no :** 010

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service;
(b) a cleaning schedule for all the equipment; and
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.77 (1). Submit the plan to LondonSAO.moh@ontario.ca.

**Grounds / Motifs :**

1. During the walk-through of the kitchen, there were many pieces of equipment and machinery that needed to be cleaned. For example, the juice machine, garbage pails, carts that are used to transport items, centre island which includes the steam table (3 dry wells and 1 steam well).
The stove was very dirty with excessive debris built up on it. The floor was noted to be very dirty around all pieces of equipment.
There was a peanut butter jar on the counter beside the mixer, with a dirty radio placed on top of the peanut butter jar and leaning against the mixer.
Fridge and freezer temperatures were being completed, but there were temperatures noted that were out of the appropriate ranges and no action noted as being taken. [O. Reg. 79/10, s. 72 (7)] (190)
2. The home's Infection Control, Sanitation and Safety Cleaning schedule policy D-05-90, dated September 2004 was reviewed to determine compliance with the LTCHA and Regulations. The policy states the food service staff must initial the cleaning schedule after each cleaning is completed.
During review of the Dietary cleaning checklist for, the period July 1-18, 2011 the home has not complied with, the cleaning schedules for the food production, servery and dish washing areas as per the homes policy when the following cleaning schedules were not initialed staff for the period July 1-18, 2011:
Steam table had not been initialed as cleaned on 14 days, or 77.7 % of the time.
Grill-had not been initialed as cleaned on 13 days, or 72.2% of the time.
Fryer had not been initialed as cleaned on 17 days, or 94.4 % of the time.
Food processor had not been initialed as cleaned on 10 days, or 55.5 % of the time.
Kitchen floor had not been initialed as cleaned on 9 days, or 50 % of the time.
Toaster drawer to be cleaned weekly had not been initialed as cleaned in the month of July as of July 18, 2011.
During a review of cleaning schedules with staff it was confirmed that the cleaning schedules had not been initialed by staff for the period July 1-18, 2011.
[O.Reg 79/10, s. 72. (7) (c)] (135)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Dec 09, 2011

## 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
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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the

Director

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.

Ontario

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

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## 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 7th day of November, 2011**

**Signature of Inspector / Signature de l'inspecteur :** Terri Daly

**Name of Inspector / Nom de l'inspecteur :** TERRI DALY

**Service Area Office / Bureau régional de services :** London Service Area Office