Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 12, 2019	2019_683126_0005	008993-18, 024512-18, 033047-18	Critical Incident System

Licensee/Titulaire de permis

Genesis Gardens Inc.
1003 Limoges Road South Limoges ON K0A 2M0

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

Foyer St-Viateur Nursing Home
1003 Limoges Road South Limoges ON K0A 2M0

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 27, 28, 29, 2019

During this Critical Incidents (CI) inspection, the following logs were inspected:
Log # 008993-18, CI # 2746-000014-18 and Log #024512-18, CI # 2746-000020-18 related to an incident that causes an injury to a resident for which the resident is taken to the hospital and which results in a significant change in the resident's health status
Log # 033047-18, CI #000025-18 related to an unexpected death

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Registered Dietitian, the Registered Nurses, the Registered Practical Nurses, Personal Support Workers, two Cooks, and two residents

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. Log # 033047-18
The licensee has failed to ensure that the home's menu cycle, (b) includes menus or regular, therapeutic and texture modified diets for both meals and snacks.

Resident #003 had several diagnoses and was on a diabetic texture modified diet. On a specific evening, resident #003 was given a snack that consisted of a minced pastrami sandwich. While eating the sandwich, resident #003 chocked.

Inspector #126 reviewed the snack menu for that evening and noted that the pastrami sandwich was not one of the item on the menu. It was also noted that the regular, the therapeutic and the texture modified diets were not documented on the snack list.

Discussion with Cook #107, who indicated that on that specific date, they prepared the evening snack cart and put the minced sandwich on the cart to be given to the residents.

Discussion held with Cook #105, who indicated that what is on the menu is available in texture modified diet and that if changes occurred they are supposed to make the changes and document on the daily menu.

Discussion held with Registered Dietitian (RD) #111, who indicated that left overs sandwiches could be given at time in the evening, for diabetic resident as it contains a carbohydrate and a protein. The snack menu was reviewed with Inspector #126 and it was noted that the minced pastrami sandwich was not documented on the snack menu for that specific day. RD #111 indicated that it was acceptable to give sandwiches in the evening as long as it was the accurate therapeutic and texture modified diet for the individual resident.

As such, the licensee does not have a menu cycles that includes menus for regular, therapeutic and texture modified diets for both meals and snacks. [s. 71. (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 that the home's menu cycle, includes menus or regular ,therapeutic and texture modified diets for both meals and snacks., to be implemented voluntarily.

Issued on this 18th day of April, 2019

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

Original report signed by the inspector.