The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that residents are provided with assistance with eating using proper feeding techniques. The plan shall include any education provided to staff and quality management activities.
The plan is to be submitted to Long-Term Care Homes Inspector Michelle Warrener by May 23, 2013, at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 73(1)10] Previously issued February 7, 2011 as a CO, March 7, 2012 as a CO
Proper feeding techniques were not used to assist residents with eating at meals.
a) Resident #23 was being fed in a chair that was tilted backwards with the resident's chin extended upwards and not tucked, creating a risk for choking. Staff did not correct the positioning until the Inspector went to the table at the lunch meal February 5, 2013.
b) Three residents (#24, 18, 25) had their mouths scraped with the spoon while being assisted with eating at the breakfast meal February 1 (3rd floor), and supper meal January 30, 2013.
c) Two residents (#25, #26) had their pureed food mixed together at the meal by staff assisting the residents. The residents were unable to voice their preferences. Staff interviewed stated one of the residents didn't like the vegetables so they were mixed together so they would eat them. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Order # /
Ordre no : 007

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

Linked to Existing Order /
Lien vers ordre existant: 2012_066107_0006, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that all hazardous substances, including identified chemicals, are kept inaccessible to residents at all times. The plan shall include:
a) measures to ensure that doors leading to the tub rooms function properly and securely lock when staff leave the room
b) quality management activities that include monitoring of the functioning of the tub room doors
c) education for staff on the importance of ensuring that all hazardous chemicals are kept inaccessible to residents at all times
The plan is to be submitted by May 23, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 91] Previously issued February 7, 2011 as a CO, March 7, 2012 as a CO
Not all hazardous substances were kept inaccessible to residents at all times. A tub room was left unlocked and unattended at 11:30 a.m. Arjo disinfectant (hazardous and poisonous) was accessible in the tub room. The inspector entered the room at 11:30 a.m and staff came at 11:35 a.m to obtain supplies for a resident. The staff member then left the tub room again and the door was left unlocked again. The inspector questioned the PSW about the unlocked door and it was identified that door was supposed to lock automatically behind the staff. The PSW and Inspector tried the door 3-4 times and the door did not lock on any of these occasions. The problem was reported to the Administrator and the door to the tub room was pulled shut and secured. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Order / Ordre :

The licensee must prepare, submit and implement a plan that outlines how the home will ensure that all residents are offered the planned menu items at meals, including:
a) the provision of correct portion sizes
b) the provision of vegetarian meals according to the therapeutic spreadsheet
c) offering bread and milk with meals according to the planned menu
The plan is to be submitted by May 23, 2013 to Long Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O. Reg. 79/10, s. 71(4)] Previously issued March 7, 2012 as a VPC
Not all residents were offered planned menu items at each meal.
a) Not all residents were offered the planned portion size of menu items. Portions offered at meals were not consistent with the planned portion sizes identified on the therapeutic extension menus. Some examples:
At the supper meal January 30, 2013, ten of the items were served using the incorrect size portion - #6 scoop required for pureed lentil casserole, #8 scoop served (smaller); 6oz portion required for regular lentil casserole, 3oz portion served; #12 scoop required for minced vegetables, and minced and pureed pears, #8 scoop served (larger); #12 scoop required for pureed bread, #10 scoop served (larger); #12 scoop required for minced salad, #10 scoop served (larger); #8 scoop required for caramel pudding, #12 scoop served (smaller). The planned menu identified serving the pureed meat and pureed bread separately for the pureed beef salad sandwich, however, the bread and meat were combined, resulted in reduced nutritional value when only 1 small scoop was used for the combined product. At the lunch meal January 25, 2013, 5 meatballs were served instead of the planned 6 meatballs, resulting in reduced

nutritional value of the meal.
b) Not all items served to residents matched the planned menu. The planned menu identified a veggie patty for the supper meal January 30, 2013, however, a vegetarian luncheon meat sandwich was served.
c) Not all items listed on the planned menu were offered to residents at meals.
i) Regular and pureed bread were identified on the planned menu, however, bread was not offered to residents at the lunch meal January 25, 2013.
ii) Bread was not offered for the minced and pureed menus at the lunch meal on February 5, 2013.
iii) Most residents requiring a pureed menu were served mashed potatoes (different food group) instead of pureed bread which was on the planned menu at the supper meal January 30, 2013 (only served bread when ran out of mashed potatoes).
d) Not all residents were offered milk or thickened milk, as per the planned menu at the lunch meals January 25 lunch, January 30 lunch, and January 31 lunch, breakfast meal February 5, 2013. Some examples:
i) Resident #04 was not offered milk at two observed meal services despite having a plan of care that indicated the resident preferred milk and required a high energy high protein menu.
ii) Resident # 22 was not offered milk. Interview with their family member who consistently assisted the resident indicated the resident was frequently not offered milk with meals and was not sure why.
iii) Resident #07 was not offered milk with their meal at the breakfast meal despite requiring a high energy high protein menu. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Order # / Ordre no : 009

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

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 shall ensure that all residents of the home are provided with the required level of assistance and encouragement with eating at meals and snacks.

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

Grounds / Motifs :

1. [O.Reg. 73(1)9] Previously issued February 7, 2011 as a CO, March 7, 2012 as a CO
Not all residents were provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible at meals.
a) At the lunch meal January 25, 2013 resident #27 was not assisted with eating and ate fairly. The resident had a plan of care requiring total assistance with eating and the dietary serving list also indicated the resident required total assistance with eating. Staff stated the resident sometimes wouldn't allow staff to assist with eating, however, staff had not approached the resident to assist or encourage until the end of the meal service where verbal prompting was offered and unsuccessful. Total assistance with eating was not offered to the resident throughout the meal. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 010

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that residents with changes in hydration or insufficient hydration, including resident #04, are identified, monitored, assessed/reassessed, and their plans of care revised to address the changes in hydration.
The plan is to be submitted by May 23, 2013 to Long Term Care Homes Inspector: Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)] Previously issued February 7, 2011 as CO, March 7, 2012 as a VPC
Resident #04 was not reassessed and their plan of care reviewed and revised when the resident's care needs changed.
a) The resident had more than a 50% decline in their hydration after hospitalization without a re-assessment of their plan of care with interventions to address the poor hydration. Documentation in the progress notes did not include any reference to poor hydration over a one month period.
b) The resident was re-assessed by the Registered Dietitian after one month of poor hydration and the resident's hydration target and diet texture was changed, however, the plan of care was not revised to reflect the changes. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 011

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that residents, including residents #02, 09, 11, have their weight measured on admission and monthly thereafter.
The plan should include: a) an assessment of the current weight monitoring systems
b) staff education provided, including the dates of the education and which staff the education is targeted to (e.g. PSW's, Registered staff) and
c) quality management activities (including the type of monitoring and frequency of monitoring) that will be implemented to target the identified area of non-compliance.
The plan is to be submitted by May 23, 2013 to Long Term Care Homes Inspector: Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 68(2)(e)] (Previously issued February 2012 as VPC under s. 8(1)(b) related to not following the weight policy)
A weight monitoring system was not in place to ensure that Resident #02 had their weight, height, and body mass index measured on admission. The resident's weight, height and body mass index was not measured and recorded when the resident's health record was reviewed 15 days after admission. Staff confirmed that the information was required for this resident and that the resident's height, weight, and body mass index were not measured on admission. (107)

2. [O.Reg. 79/10, s. 68(2)(e)(i)]
The licensee did not ensure that resident #11 had their weight measured and recorded at least monthly. The resident did not have their weight recorded for one month. The resident was in hospital for 11 days at the beginning of the month, however, the resident's weight was not taken or recorded upon return from hospital. Interview and documentation did not include rationale as to why the resident's weight was not taken and recorded and staff confirmed the resident's weight was required to be taken upon return from hospital. The resident had new and multiple areas of skin breakdown upon return from hospital. (107)

3. [O.Reg. 79/10, s. 68(2)(e)(i)]
Resident #09 did not have their weight measured and recorded one month. A weight was not recorded in the computer, the bath record sheet, the re-weight sheets, nor in the progress notes. The resident had a 10.6% significant weight loss over three months with no weight recorded for two of the three months within the three month period. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board

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
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 9th day of May, 2013

Signature of Inspector / Signature de l'inspecteur : M Warrener

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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