Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 15, 2016	2016_336620_0008	004720-14	Complaint

Licensee/Titulaire de permis

IOOF SENIORS HOMES INC.
20 Brooks Street BARRIE ON L4N 5L3

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

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET BARRIE ON L4N 5L3

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

ALAIN PLANTE (620), FRANCA MCMILLAN (544)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 16-19, 2016, and February 22-26, 2016

During the course of the inspection, the inspector(s) reviewed residents' clinical records, residents' plans of care, various policies/procedures/programs, observed the provision of care, resident to resident interaction, meal services, conducted staff interviews, and conducted resident and family interviews.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Nursing and Personal Care (DOC), the Nurse Manager, the Food Services Manager, the Resident Care Administrative Assistant, the Human Resources Manager, the Nurse Practitioner (NP), the Physiotherapist, the Convalescent Care Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Aides, a Behavioural Services Ontario Consultant (BSO), Members of the Barrie Police Services, and residents and residents' family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Medication
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Resident Charges
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
1 VPC(s)
4 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #544 reviewed a complaint submitted to the Ministry of Health and Long-Term Care (MOHLTC). The complaint alleged that resident #002 was being negatively impacted by medication that was being administered for symptoms related to pain.

Inspector #544 reviewed resident #002's health care record and identified that the resident experienced pain for which they received medication. Resident #002's health care record also revealed that resident #002 was admitted to the home with altered skin integrity.

Inspector #544 reviewed progress notes for resident #002. The progress notes revealed that resident #002 had altered skin integrity that that deteriorated. The clinical record indicated that the physician ordered a stronger pain relieving medication due to the severe pain as a result of the resident's altered skin integrity.

Inspector #544 further reviewed the resident's clinical record to determine if the resident's care plan identified the resident's pain, and whether the resident's pain was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

The clinical record revealed that the resident was experiencing pain; however, pain was not identified in the resident's initial care plan. The clinical record also revealed that on five occasions, resident #002 experienced a change to their level of pain which required an increase of the resident's medication; none of the changes in condition were identified

in the resident's care plan.

Inspector #544 reviewed resident #002's care plans the care plans had not identified any focus, goals, or interventions to address resident #002's pain; which, according to the progress notes, was severe and had progressed to more severe. Furthermore, the care plans had not been revised as resident #002's pain increased and subsequently decreased. The care plans did not contain any interventions to address the needs of resident #002 regarding their pain, the pattern of the pain, including the potential or actual impact of pain on the resident's functional abilities. The care plans also did not identify the potential impact of the pharmacological intervention and their potential side effects.

Inspector #544 interviewed the DOC and RPN #116 who both confirmed that the current care plan, and the three previous care plans had not identified pain as a focus that included goals and interventions. The DOC stated that the care plans should have been reviewed and revised to address resident #002's changing level of pain, and that this had not occurred, and should have.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm and although the scope was isolated, there was a compliance history previously issued in a similar area of the legislation with three Voluntary Plans of Correction (VPC) having been issued between April 07, 2015, and February 27, 2014. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that at least annually, the responsive behaviour program was evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and, failed to ensure that a written record was kept related to each evaluation under clause (b) that included the date of the evaluation, the names of the persons who participated in the evaluation and, a summary of the changes made and the date those changes were implemented.

Inspector #544 reviewed one of the home's required programs titled, "Subject: Responsive Behaviour Program, Policy #RCM 12-04-01." The document identified that the effective date for the home's Responsive Behaviours Program was July 2014. There was no documentation to support that this program had been reviewed annually.

Inspector #544 interviewed the DOC. The DOC could not provide the Inspector with any documentation that the Responsive Behaviours Program was evaluated annually, the date of the evaluation, the names of the persons who participated, the summary of the changes made, and the date that those changes were implemented. The DOC stated that it was the home's expectation that the Responsive Behaviours Program was to be reviewed annually, and that this had not occurred, and should have.

The decision to issue this compliance order was based on the severity which indicated a potential risk for actual harm, the scope of the issue was widespread, there was a history of unrelated previously issued non-compliance within the last three years. [s. 53. (3) (b)]

2. The licensee failed to ensure that actions were taken to respond to the needs of a resident with responsive behaviours including assessments, reassessments, and documentation of the resident's responses to the interventions.

Inspector #544 reviewed a complaint that was submitted to the MOHLTC. The complaint was related to the home's management of resident #006's responsive behaviours. The complainant alleged that resident #006 exhibited responsive behaviours towards staff and other residents and that, "no actions have been taken."

Inspector #544 reviewed resident #006's health care record and identified that the resident exhibited responsive behaviours. There was no documentation in resident #006's health care record which identified that resident #006 was referred to specialized behavioural resources, or that an assessment or re-assessment had been completed for resident #006 regarding their responsive behaviours. There was also no documentation to support that responsive behaviour documentation was completed for resident #006.

The Inspector reviewed the home's Responsive Behaviours Program, "Policy #RCM 12-04-01". The policy stated, "The home is committed to using the physical, intellectual, emotional, capabilities, environmental, social (P.I.E.C.E.S.) model to address responsive behaviours." There was no documentation in resident #006's health care record to support that the P.I.E.C.E.S. model was completed. Furthermore, the policy identified specific responsive behaviour documentation as a screening protocol and screening tool to "flag" the resident's behaviours. There was no documentation to support that specific responsive behaviour documentation was completed for resident #006.

Further review of the home's policy on responsive behaviours revealed that registered staff were expected to conduct an assessment, document a "Behaviour note" in Point

Click Care, send a referral to the Nurse Practitioner, and refer the resident to the specialized behavioural consultant.

Inspector #544 interviewed staff member #115 who stated that there was no responsive behaviour documentation in resident #006's health care record since their admission and that resident #006 exhibited responsive behaviours on a daily basis.

Inspector #544 interviewed the home’s specialized behavioural consultant and the Nurse Practitioner who both stated that they had not received a referral for an assessment for resident #006's responsive behaviours and that they should have received one.

Inspector #544 interviewed staff member #117 and #118. Both stated that no behavioural assessment or responsive behaviour documentation was completed for resident #006, nor was there a referral to the Nurse Practitioner or to the behavioural consultant. They both confirmed that it was the home’s expectation that behavioural assessment, specialized responsive behaviour documentation, and referral to the Nurse Practitioner and the behavioural consultant should have been done, and that this had not occurred, and should have. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids were prepared, stored, and served using methods which prevented adulteration, contamination and food borne-illness.

Inspector #544 reviewed a complaint submitted to the MOHLTC. The complaint alleged that beverages were being pre-poured at 1110 hours and were left for 50 minutes uncovered, and at room temperature because the residents did not attend the lunch meal until 1200 hours.

On February 16, 2016, at 1120 hours, in the home's entrance dining hall, Inspector #544 and #620 observed that the beverages, for the residents' lunch meals were pre-poured into uncovered glasses/cups and placed on to the dining tables, at individual place settings, 40 minutes before the lunch meal was scheduled to be attended by residents. The same serving condition for beverages was observed on February 17, at 1115 hours, and on February 18, at 0750 hours, for the breakfast meal that was to be served at 0830 hours.

Inspector #544 reviewed the home's Food Service Policy. Policy #FS-03-02-05 stated to, "Place milk, juice, creamers, and water on the table no more than 15 minutes before the meal is served."

Inspector #544 interviewed staff member #125 and #126. Both told the Inspector that they had pre-poured the beverages for the meals 40 minutes before the start of the meal. Both staff members confirmed that they were not following the home's policy.

Inspector #544 interviewed the Food Service Manager. They stated that pre-pouring the beverages in excess of 30 minutes before the meal was not acceptable. They also confirmed that staff pre-poured the beverages into the cups/glasses too early before the meal time. The Food Service Manager agreed that the beverage service should be provided to the residents when they enter the dining room and not be pre-poured. They further stated that the beverages should have been freshly poured to maintain their freshness, to prevent adulteration, and contamination and food borne-illness.

The decision to issue this compliance order was based on the severity which indicated a potential risk for actual harm, the scope of the issue was widespread; there was a compliance history previously issued in this identical area of the legislation with a VPC having been issued to the home on November 13, 2014. [s. 72. (3) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that direct care staff were provided training in the area of pain management, including recognition of specific and non-specific signs of pain.

Inspector #544 requested the home’s training records related to pain management, including recognition of specific and non-specific signs of pain. The DOC confirmed that the home had no such records or pain specific training.

Inspector #544 interviewed five staff members; all confirmed that they were not provided training in the area of pain management, including recognition of specific and non-specific signs of pain.

Inspector #544 interviewed the DOC. The DOC stated that staff had not received training in the area of pain management, including recognition of specific and non-specific signs of pain, and should have.

The decision to issue this compliance order was based on the severity which indicated a potential risk for actual harm, the scope of the issue was widespread; there was a history of unrelated non-compliance issued to the home in the last three years. [s. 221. (1) 4.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted:
- Every resident has the right to have his or her participation in decision-making respected.

On February 16, 17, and 18, 2016, Inspector #544 and #620 observed that the beverages for the residents' meals were already pre-poured 40 minutes in advance of the meal. The inspectors observed that the residents would enter the dining room and sit in their designated seat. The inspectors observed that residents were not being offered a beverage choice either before the meal had begun or during the meal service.

Inspector #544 interviewed staff member #125 and #126; both told the Inspector that pre-pouring of the beverages for the meals should have occurred no earlier than 30 minutes before the start of the meal but some staff did not follow this direction. They both confirmed that the residents were not being offered beverage options during or before the meal services.

Inspector #544 interviewed the Food Service Manager who stated that pre-pouring the beverages in excess of 30 minutes before the meal was not acceptable. They also confirmed that staff members were pre-pouring the beverages into the cups/glasses too early before the meal time. They stated that the beverage service should be provided to the residents when they had entered the dining room for their meal. The Food Service Manager further stated that when beverages were pre-poured it did not allow the residents the right to choose what beverage they would like, which hindered their participation in decision-making. [s. 3. (1) 9.]

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 by making certain that every resident has the right to have his or her participation in decision-making respected, to be implemented voluntarily.

Issued on this 2nd day of May, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALAIN PLANTE (620), FRANCA MCMILLAN (544)
Inspection No. / No de l'inspection :	2016_336620_0008
Log No. / Registre no:	004720-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 15, 2016
Licensee / Titulaire de permis :	IOOF SENIORS HOMES INC. 20 Brooks Street, BARRIE, ON, L4N-5L3
LTC Home / Foyer de SLD :	ODD FELLOW AND REBEKAH HOME 10 BROOKS STREET, BARRIE, ON, L4N-5L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Doreen Saunders

To IOOF SENIORS HOMES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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:

1.) Develop and implement a process to ensure that residents' plans of care are reviewed and revised when residents' care needs change,

a.) Ensure that the developed process identifies who is responsible for reviewing and revising the plans of care,

2.) Train all staff who are responsible for the review and revision of plans of care on how and when to revise plans of care, and

3.) Develop and implement a process to audit compliance with ensuring the residents' plans of care are reviewed and revised when residents' care needs change.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #544 reviewed a complaint submitted to the Ministry of Health and

Long-Term Care (MOHLTC). The complaint alleged that resident #002 was being negatively impacted by medication that was being administered for symptoms related to pain.

Inspector #544 reviewed resident #002's health care record and identified that the resident experienced pain for which they received medication. Resident #002's health care record also revealed that resident #002 was admitted to the home with altered skin integrity.

Inspector #544 reviewed progress notes for resident #002. The progress notes revealed that resident #002 had altered skin integrity that that deteriorated. The clinical record indicated that the physician ordered a stronger pain relieving medication due to the severe pain as a result of the resident's altered skin integrity.

Inspector #544 further reviewed the resident's clinical record to determine if the resident's care plan identified the resident's pain, and whether the resident's pain was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

The clinical record revealed that the resident was experiencing pain; however, pain was not identified in the resident's initial care plan. The clinical record also revealed that on five occasions, resident #002 experienced a change to their level of pain which required an increase of the resident's medication; none of the changes in condition were identified in the resident's care plan.

Inspector #544 reviewed resident #002's care plans the care plans had not identified any focus, goals, or interventions to address resident #002's pain; which, according to the progress notes, was severe and had progressed to more severe. Furthermore, the care plans had not been revised as resident #002's pain increased and subsequently decreased. The care plans did not contain any interventions to address the needs of resident #002 regarding their pain, the pattern of the pain, including the potential or actual impact of pain on the resident's functional abilities. The care plans also did not identify the potential impact of the pharmacological intervention and their potential side effects.

Inspector #544 interviewed the DOC and RPN #116 who both confirmed that the current care plan, and the three previous care plans had not identified pain as a

focus that included goals and interventions. The DOC stated that the care plans should have been reviewed and revised to address resident #002's changing level of pain, and that this had not occurred, and should have.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm and although the scope was isolated, there was a compliance history previously issued in a similar area of the legislation with three Voluntary Plans of Correction (VPC) having been issued between April 07, 2015, and February 27, 2014. [s. 6. (10) (b)] (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 13, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Order / Ordre :

The licensee shall:

1.) Conduct a comprehensive review of the home's Responsive Behaviour program, in order to ensure compliance with all elements of the legislative and regulatory requirements

2.) Keep a written record related of the evaluation of the Responsive Behaviours Program including:

a) the date of the evaluation,
b) the names of the persons who participated in the evaluation, and
c) a summary of the changes made and the date those changes were implemented.

3.) Ensure all staff who provide direct care to residents are provided education and training in the revised program and policies, and maintain a record of the training.

Grounds / Motifs :

1. The licensee failed to ensure that at least annually, the responsive behaviour program was evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and, failed to ensure that a written record was kept related to each evaluation under clause (b) that included the date of the evaluation, the names of the persons who participated in the evaluation and, a summary of the changes made and the date those changes were implemented.

Inspector #544 reviewed one of the home's required programs titled, “Subject: Responsive Behaviour Program, Policy #RCM 12-04-01.” The document identified that the effective date for the home’s Responsive Behaviours Program was July 2014. There was no documentation to support that this program had been reviewed annually.

Inspector #544 interviewed the DOC. The DOC could not provide the Inspector with any documentation that the Responsive Behaviours Program was evaluated annually, the date of the evaluation, the names of the persons who participated, the summary of the changes made, and the date that those changes were implemented. The DOC stated that it was the home’s expectation that the Responsive Behaviours Program was to be reviewed annually, and that this had not occurred, and should have.

The decision to issue this compliance order was based on the severity which indicated a potential risk for actual harm, the scope of the issue was widespread, there was a history of unrelated previously issued non-compliance within the last three years. [s. 53. (3) (b)] (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 10, 2016

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall:

1.) Conduct a comprehensive review of the home's policy on food preparation, storage, and serving methods, ensuring that the policy includes procedures to prevented adulteration, contamination and food borne-illness,

2.) Maintain a summary of the changes made to the policy

3.) Ensure that all staff responsible for food preparation, storage, and serving are trained on the revised policy, and

4.) Maintain a record of all staff who receive training on the revised policy, and the dates that the training occurred.

Grounds / Motifs :

1. The licensee failed to ensure that all food and fluids were prepared, stored, and served using methods which prevented adulteration, contamination and food borne-illness.

Inspector #544 reviewed a complaint submitted to the MOHLTC. The complaint alleged that beverages were being pre-poured at 1110 hours and were left for 50 minutes uncovered, and at room temperature because the residents did not attend the lunch meal until 1200 hours.

On February 16, 2016, at 1120 hours, in the home's entrance dining hall,

Inspector #544 and #620 observed that the beverages, for the residents' lunch meals were pre-poured into uncovered glasses/cups and placed on to the dining tables, at individual place settings, 40 minutes before the lunch meal was scheduled to be attended by residents. The same serving condition for beverages was observed on February 17, at 1115 hours, and on February 18, at 0750 hours, for the breakfast meal that was to be served at 0830 hours.

Inspector #544 reviewed the home's Food Service Policy. Policy #FS-03-02-05 stated to, "Place milk, juice, creamers, and water on the table no more than 15 minutes before the meal is served."

Inspector #544 interviewed staff member #125 and #126. Both told the Inspector that they had pre-poured the beverages for the meals 40 minutes before the start of the meal. Both staff members confirmed that they were not following the home's policy.

Inspector #544 interviewed the Food Service Manager. They stated that pre-pouring the beverages in excess of 30 minutes before the meal was not acceptable. They also confirmed that staff pre-poured the beverages into the cups/glasses too early before the meal time. The Food Service Manager agreed that the beverage service should be provided to the residents when they enter the dining room and not be pre-poured. They further stated that the beverages should have been freshly poured to maintain their freshness, to prevent adulteration, and contamination and food borne-illness.

The decision to issue this compliance order was based on the severity which indicated a potential risk for actual harm, the scope of the issue was widespread; there was a compliance history previously issued in this identical area of the legislation with a VPC having been issued to the home on November 13, 2014.
[s. 72. (3) (b)] (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 13, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall:

1.) Develop a training program in the area of pain management, including recognition of specific and non-specific signs of pain, in accordance with evidence- based practices

2.) Ensure that all direct care staff are trained in the area of pain management, and

3.) Maintain a record of all staff who receive pain management training, and the dates that the training occurred.

Grounds / Motifs :

1. The licensee failed to ensure that direct care staff were provided training in the area of pain management, including recognition of specific and non-specific signs of pain.

Inspector #544 requested the home's training records related to pain management, including recognition of specific and non-specific signs of pain. The DOC confirmed that the home had no such records or pain specific training.

Inspector #544 interviewed five staff members; all confirmed that they were not provided training in the area of pain management, including recognition of specific and non-specific signs of pain.

Inspector #544 interviewed the DOC. The DOC stated that staff had not received training in the area of pain management, including recognition of specific and non-specific signs of pain, and should have.

The decision to issue this compliance order was based on the severity which indicated a potential risk for actual harm, the scope of the issue was widespread; there was a history of unrelated non-compliance issued to the home in the last three years. [s. 221. (1) 4.] (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 24, 2016

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Inspection de sions de longue durée 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 15th day of April, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Alain Plante

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