Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 18, 2012	2012_122156_0023	H-002078-12	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

PEEL MANOR
525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9

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

CAROL POLCZ (156)

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): October 23, 2012

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), registered staff, Dietary Manager, Personal Support Workers (PSW's), Dietary Aides, residents

During the course of the inspection, the inspector(s) reviewed residents' clinical records, observed meal service, reviewed thickened fluids procedure and prepared products in the main kitchen and dining areas.

This inspection was conducted in reference to Log #H-002078-12

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Resident #001 had a diet order for honey thickened fluids. The accessible plan of care and the dietary servery sheet identified the resident was on nectar consistency thickened fluids. In 2012, the resident choked after being provided nectar thickened fluids during the breakfast meal and subsequently died. Staff confirmed the resident was provided with nectar consistency thickened fluids.
Resident #002 had a physician order for nectar consistency thickened fluids. In 2012, during the lunch meal the resident was provided with regular (thin) tea, and milk that was found to be not thickened properly. The pre-thickened milk had separated into 3 distinct layers. When tilted, the fluid flowed very thin and when stirred there were chunks of white matter left on the spoon. The Food Service Supervisor confirmed the milk had not been thickened properly. Observation of the main fridge by the inspector and the Food Service Supervisor in October 2012 found that the pre-thickened milk had been prepared as much as six days in advance and also had separated liquid.
Resident #003 had a physician order for pudding thickened fluids. In 2012 during the lunch meal, the inspector observed the resident had received water that was not at a pudding consistency. [s. 11. (2)]

2. The licensee did not ensure residents were provided with food and fluids that are safe, adequate in quantity, nutritious and varied.
1. Resident #002 had a physician order for nectar consistency thickened fluids. In 2012, during the lunch meal the resident was eating soup and was coughing when the inspector entered the dining room. The soup was found to be of regular (thin) consistency and was not thickened. When brought to the attention of staff, it was replaced with thickened soup. The resident's milk was thickened to a nectar consistency, however, it was found to have small chunks in it. When brought to the Food Supervisors' attention, the inspector was told that the thickener had not dissolved fully.
2. Resident #005 had a physician order for honey thickened fluids. It was observed by the inspector during the nourishment pass in October 2012, that the fluids on the nourishment cart for this resident was not of honey consistency, although labeled as such. The fluid was of nectar consistency. The inspector prevented the fluids from being provided to the resident. The dietary aide who prepared the fluid confirmed it was nectar consistency. [s. 11. (2)]

Additional Required Actions:

CO # - 901, 902 were served on the licensee. CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Staff and others who provide direct care to a resident were not kept aware of the contents of the plan of care and given convenient and immediate access to it. Resident 001 had a diet order change from nectar thickened fluids to honey thickened fluids in 2012 and the careplan was subsequently changed on the computer by the Registered Dietitian on that day. As confirmed by the DOC, the accessible careplan for staff to provide direction for care for the resident indicated nectar consistency thickened fluids on the day the resident choked. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it, to be implemented voluntarily.

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

**COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 11. (2)	CO #902	2012_122156_0023	156

Issued on this 9th day of January, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Carol Polz, RD.

Ministry of Health and Long-Term Care

Ministère 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

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) :	CAROL POLCZ (156)
Inspection No. / No de l'inspection :	2012_122156_0023
Log No. / Registre no:	H-002078-12
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 18, 2012
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF PEEL 10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	PEEL MANOR 525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~RANJIT CALAY~~ Jan Egan

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

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that thickened fluids are prepared and provided in the consistency following the current physician or dietitian order and that all pre-prepared thickened products are stored in a manner that preserves consistency.

Grounds / Motifs :

1. The licensee did not ensure residents were provided with food and fluids that are safe, adequate in quantity, nutritious and varied.
Resident #001 had a diet order for honey thickened fluids dated September, 2012. The accessible plan of care and the dietary servery sheet identified the resident was on nectar consistency thickened fluids. In October, 2012, the resident choked after being provided nectar thickened fluids and subsequently died. Staff confirmed the resident was provided with nectar consistency thickened fluids.
Resident #002 had a physician order for nectar consistency thickened fluids. On October 23, 2012, during the lunch meal the resident was provided with regular (thin) tea, and milk that was found to be not thickened properly. The pre-thickened milk had separated into 3 distinct layers. When tilted, the fluid flowed very thin and when stirred there were chunks of white matter left on the spoon. The Food Service Supervisor confirmed the milk had not been thickened properly. Observation of the main fridge by the inspector and the Food Service Supervisor in October, 2012 found that the pre-thickened milk had been prepared as much as six days in advance and also had separated liquid.
Resident #003 had a physician order for pudding thickened fluids. In October, 2012 during the lunch meal, the inspector observed the resident had received water that was not at a pudding consistency.
(156)

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

Order # / Ordre no : 902 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2012_122156_0023, CO #901;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that thickened fluids are prepared and provided in the consistency following the current physician or dietitian order.

Grounds / Motifs :

1. The licensee did not ensure residents were provided with food and fluids that are safe, adequate in quantity, nutritious and varied.
Resident #002 had a physician order dated for nectar consistency thickened fluids. In October, 2012, during the lunch meal the resident was eating soup and was coughing when the inspector entered the dining room. The soup was found to be of regular (thin) consistency and was not thickened. When brought to the attention of staff, it was replaced with thickened soup. The resident's milk was thickened to a nectar consistency, however, it was found to have small chunks in it. When brought to the Food Supervisors' attention, the inspector was told that the thickener had not dissolved fully.
Resident #005 had a physician order for honey thickened fluids. It was observed by the inspector during the nourishment pass in October, 2012, that the fluids on the nourishment cart for this resident was not of honey consistency, although labeled as such. The fluid was of nectar consistency. The dietary aide who prepared the fluid confirmed it was nectar consistency (156)

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

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will prepare, submit and implement a plan for achieving compliance to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. The plan should include: a) assessment of the current method for communicating resident food and fluid orders b) staff education to be completed, including dates of the education c) which staff education is targeted (ie: PSW's, dietary aides, etc) and d) quality management activities (including the type of activities and frequency) that will be implemented to target the identified area of non compliance. The plan should be submitted via email to Carol Polcz, LTC Homes Inspector, Ministry of Health and Long Term Care, 119 King Street West, 11th Floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca by December 7, 2012.

Grounds / Motifs :

1. The licensee did not ensure residents were provided with food and fluids that are safe, adequate in quantity, nutritious and varied.
Resident #001 had a diet order for honey thickened fluids. The accessible plan of care and the dietary servery sheet identified the resident was on nectar consistency thickened fluids. In October, 2012, the resident choked after being provided nectar thickened fluids during the breakfast meal and subsequently died. Staff confirmed the resident was provided with nectar consistency thickened fluids.

Resident #002 had a physician order for nectar consistency thickened fluids. In October, 2012, during the lunch meal the resident was provided with regular (thin) tea, and milk that was found to be not thickened properly. The pre-

thickened milk had separated into 3 distinct layers. When tilted, the fluid flowed very thin and when stirred there were chunks of white matter left on the spoon. The Food Service Supervisor confirmed the milk had not been thickened properly. Observation of the main fridge by the inspector and the Food Service Supervisor in October, 2012, found that the pre-thickened milk had been prepared as much as six days in advance and also had separated liquid.
In October, 2012, during the lunch meal, the resident was eating soup and was coughing when the inspector entered the dining room. The soup was found to be or regular (thin) consistency and was not thickened. When brought to the attention of staff, it was replaced with thickened soup. The resident's milk was thickened to a nectar consistency, however, it was found to have small chunks in it. When brought to the Food Service Supervisors' attention, the inspector was told that the thickener had not dissolved fully.

Resident #003 had a physician order for pudding thickened fluids. In October, 2012, during the lunch meal, the inspector observed the resident had received water that was not at a pudding consistency.

Resident #005 had a physician order for honey thickened fluids. It was observed by the inspector during the nourishment pass in October, 2012 that the fluids on the nourishment cart for this resident was not of honey consistency, although labelled as such. The fluid was of nectar consistency. The inspector prevented the fluids from being provided to the resident. The dietary aide who prepared the fluid confirmed it was nectar consistency.
(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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 and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of October, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : CAROL POLCZ

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