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 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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 22, 2018 | 2018_668543_0012 | 005638-18 | Resident Quality Inspection |

### Licensee/Titulaire de permis

Anson General Hospital
58 Anson Drive IROQUOIS FALLS ON P0K 1E0

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

South Centennial Manor
240 Fyfe Street IROQUOIS FALLS ON P0K 1E0

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

TIFFANY BOUCHER (543), STEPHANIE DONI (681)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): April 17-20 and 23-27, 2018**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Accountant, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Support Ontario (BSO) Recreation Therapist and Support Services Program Lead, residents and their family members.**

**The Inspectors conducted a daily tour of the resident care areas, observed the provision of care and services to residents, observes meal services, observed staff to resident interactions, reviewed relevant health care records, licensee policies, procedures and programs.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Residents' Council**
**Skin and Wound Care**

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

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

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

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

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the nutrition care and dietary services program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Section 70 of Ontario Regulation (O. Reg.) 79/10, indicates that the dietary services component of the nutrition care and dietary services program must include: menu planning; food production; dining and snack service; and availability of supplies and equipment for food production and dining and snack service.

Inspector #681 requested the home's policy related to monitoring of residents during meal service from the Support Service Program Lead; however, the Support Service Program Lead was unable to provide Inspector #681 with the document.

Inspector #681 reviewed the home's nutrition care and dietary services program and noted that some of the policies and procedures related to food production, food storage, food safety, sanitization, pureed/minced meals, and thickened fluids had not been reviewed in the past year and that some of these policies had not been updated since 2008.

During an interview with the Support Services Program Lead, they stated that some of the policies related to dietary services were reviewed by the nutrition managers from the MICs Group in 2016; however, not all of the policies were reviewed or updated at that time. The Support Service Program Lead was unable to provide the Inspector with any documentation related to which policies were reviewed or revised in 2016.

During an interview with RD #101, they stated that they were involved in developing the home's nutrition care policies in 2016 and that these policies were reviewed and revised in 2017. However, RD #101 stated that any of the policies related to food services were developed by the nutrition managers from the MICs Group and that these policies were not developed or reviewed by RD #101. RD #101 stated that they were not aware of any home policy that was related to the following topics: thickened fluids, texture modified diets, monitoring of residents during meals, and monitoring food and fluid intake.

During an interview with the DOC, they stated that they were not aware of any dietary services policies that were reviewed or revised in the past year. [s. 30. (1) 3.]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager**

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

**s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a nutrition manager was on site at the home working in the capacity of nutrition manager for the minimum number of hours per week outlined in the O. Reg. 79/10, without including any hours spent fulfilling other responsibilities.

Section 75 (4) of the O. Reg. 79/10, identified that a home with a licensed bed capacity of 69 beds would require a nutrition manager to be on site and working in the capacity of a nutrition manager for a minimum of 22.1 hours per week.

During an interview with the Support Services Program Lead, they indicated that they were responsible for managing the food service, housekeeping and laundry departments in the home. The Support Services Program Lead stated that they were in the home for approximately four hours per day or 20 hours per week, and they spent the majority of their time managing the food service department. However, the Support Services Program Lead was unable to elaborate further on how they divided their time spent in the home.

Inspector #681 reviewed the job description for the Support Services Program Lead, which indicated that they were responsible for the administration, health and safety, human resources management, and supervision of the Dietary, Housekeeping, and Laundry departments.

During an interview with the home's accountant, they stated that the Support Services Program Lead was a shared employee between the home and the local hospital. The home's accountant stated that the Support Services Program Lead was funded at the home as a 0.61 full-time equivalent (FTE) and that this was the equivalent of approximately 23 hours per week.

During an interview with the DOC, they acknowledged that the Support Services Program Lead was not meeting the minimum number of hours outlined in the O. Reg. 79/10 when all of their other duties were taken into account. The DOC stated that the Support Services Program Lead was not meeting the minimum number of hours in the home. [s. 75. (3)]

***Additional Required Actions:***

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

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

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

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).**

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's menu cycle was approved by a registered dietitian, who was a member of the staff of the home.

During an interview with Inspector #681, RD #101, they indicated that they were responsible for reviewing the home's menu, but that they did not believe that the home's menu had been reviewed or revised in "a while".

Inspector #681 reviewed the home's policy titled "Menu Planning" (LTC-414), last updated December 20, 2016, which indicated that prior to implementation, the menu must be reviewed and approved by a registered dietitian.

During an interview with the Support Services Program Lead, they stated that the current Fall/Winter Menu was implemented in September 2017, and that the home would be putting out a new menu starting in May 2018. The Support Services Program Lead stated that they did not have any documentation to support that the 2016, or 2017, menus were approved by RD #101 and that, based on available documentation, the last time that the home's menu was reviewed by the RD was in April 2015. [s. 71. (1) (e)]

2. The licensee has failed to ensure that the home's menu cycle was reviewed by the Resident's Council for the home.

During an interview with Inspector #682, resident #006, they indicated that they regularly attended Residents' Council meetings; however, they did not recall reviewing the home's menu cycle.

Inspector #681 reviewed the Residents' Council meeting minutes and was unable to locate any documentation to support that the home's menus had been reviewed by Resident Council.

During an interview with the BSO Recreation Therapist, they stated that the home's menu had not been reviewed by Residents' Council since March 25, 2016.

Inspector #681 reviewed the "Nutrition and Hydration Program" (LTC-008), last revised February 16 2017, which indicated that there was to be consultation and approval from the Residents' Council for menu development.

During an interview with the Support Services Program Lead, they stated that the home's menu was last revised in September 2017. The Support Services Program Lead verified that Residents' Council did not review this menu prior to it being implemented. [s. 71. (1) (f)]

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with 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 has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least 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.

On April 18, 2018, Inspector #681 interviewed RPN #111 who indicated that resident #002 had fallen on a specific date in 2018.

Inspector #543 reviewed the home's "Falls Management and Prevention Program" (LTC-001), which indicated that a resident who had fallen would be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post fall care management needs. This policy identified that the resident's care plan would be modified and completed as soon as possible. The home's policy indicated that registered staff would ensure that a fall risk assessment was completed on admission, quarterly and with any change in the resident's condition, and that the registered staff would initiate the residents' plan of care to identify risk and strategies to address the levels of risks.

Inspector #543 observed this resident #002 on:

-April 19 and 24, 2018, the resident was observed lying in bed with an assistive device at end of their bed; and
-April 20, 2018, the resident was observed ambulating in the hallway with the use of an assistive device.

Inspector #543 reviewed this resident's most recent care plan, related to falls which identified that resident #002 was at a specific risk for falls and utilized an assistive device for mobility.

Inspector #543 reviewed resident #005's Morse Fall Scale that were completed on:

-February 26, 2018, which identified that resident #002 was at a specific risk for falling; and
-March 28, 2018, which identified that resident #002's risk for falling had increased.

Inspector #543 interviewed PSW #100, who verified that resident #002 required an assistive device for mobility since they fell on a date in 2018.

The Inspector interviewed RN #108 who verified resident #002's care plan had not been updated to reflect the need for an assistive device, or for the change in their fall risk.

The Inspector interviewed the DOC specifically related to resident #002's fall that occurred on a date 2018. The DOC verified that the resident's care plan should have been updated to reflect that resident #002's change in fall risk and required the use of an assistive device for mobility. [s. 6. (10) (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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan of care is no longer necessary, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that that the requirements of this section were met with respect to every plan of care, in that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: health conditions, including allergies, pain, risk of falls and other special needs.

Inspector #681 interviewed RPN #111 who indicated that resident #005 had fallen on a date in 2018.

Inspector #543 reviewed the home’s “Falls Management and Prevention Program” (LTC-001), which indicated that registered staff would ensure that a fall risk assessment was completed on admission, quarterly and with any change in the resident's condition, and that the registered staff would initiate the resident's plan of care to identify risk and strategies to address the levels of risks.

Inspector #543 reviewed resident #005’s progress notes, dated April 10, 2018, which identified that the resident had fallen multiple time on specific dates in 2018.

Inspector #543 reviewed this resident’s most recent care plan, specifically related to falls and the risk of falls. There was no fall focus identified related to the resident’s history of falling or risk of falling in the resident's care plan.

The Inspector interviewed RN #108, specifically related to falls, who verified that resident #005’s care plan did not contain a focus related to falls or the risk of falling, nor had the resident's care plan been updated since the resident fell in April of 2018.

The Inspector interviewed the DOC specifically related to resident #005’s fall that occurred on a date in 2018. The DOC verified that the resident's care plan should have addressed the resident's risk for falls and that when resident #005’s Morse Fall Assessment was completed on their admission, their plan of care should have identified that this resident was at a high risk for falling. [s. 26. (3) 10.]

***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 that the requirements of this section are met with respect to every plan of care, in that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where the Long-Term Care Homes Act (LTCHA) or Ontario Regulation (O. Reg) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg 79/10 s. 68. (2) (e) (ii), the licensee was required to ensure a weight monitoring system to measure and record, with respect to each resident, body mass index and height upon admission and annually thereafter.

Through record reviews, Inspectors #543 and #681 identified that residents #003, #004, #007, #008, #009, #010 had not had a height completed since 2016.

During an interview with the Inspector, RD #101 stated that heights should be completed annually and verified that an annual height had not been completed for residents #003, #004, #007, #008, #009, and #010.

Inspector #681 reviewed the home's policy titled "Weight and Height Audit and Weight Change Protocol" (LTC-417), last updated December 20, 2016, which indicated that residents were to have their height measured on admission and that their height was to be reassessed annually thereafter.

During an interview with the DOC, they stated that heights were to be completed annually with the annual MDS assessment. [s. 8. (1) (a),s. 8. (1) (b)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:**

**1. A change of 5 per cent of body weight, or more, over one month.**
**2. A change of 7.5 per cent of body weight, or more, over three months.**
**3. A change of 10 per cent of body weight, or more, over 6 months.**
**4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents with a weight change of five percent of body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Through a staff interview, resident #003 was identified as having a specific body mass index (BMI).

Inspector #681 reviewed resident #003's weight history and identified a weight change of 7.8 per cent between February 2018, and March 2018. Inspector #681 reviewed resident #003's electronic medical record and was unable to find any assessments related to this weight change.

Inspector #681 reviewed the home's policy titled "Weight and Height Audit and Weight Change Protocol" (LTC-417) last revised December 20, 2016, which indicated that a referral would be made to the Dietitian for unplanned weight loss of greater than or equal to five per cent over one month and that the Dietitian would conduct an assessment of each resident referred and investigate possible nutrition factors responsible for weight change.

During an interview with RD #101, they stated that resident #003 was not reweighed, nor were they assessed following their March 2018, weight. RD #101 verified that this weight change warranted an assessment and that this assessment was not completed.

During an interview with the DOC, they stated that a reweigh was not completed on the March 2018, weight and that there was no documentation to support that the weight change was reviewed or assessed by a member of the interdisciplinary team. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 sous la Loi de 2007 sur les foyers de soins de longue durée**

**Issued on this 23rd day of May, 2018**

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

**Original report signed by the inspector.**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | TIFFANY BOUCHER (543), STEPHANIE DONI (681) |
| **Inspection No. / No de l'inspection :** | 2018_668543_0012 |
| **Log No. / No de registre :** | 005638-18 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | May 22, 2018 |
| **Licensee / Titulaire de permis :** | Anson General Hospital<br>58 Anson Drive, IROQUOIS FALLS, ON, P0K-1E0 |
| **LTC Home / Foyer de SLD :** | South Centennial Manor<br>240 Fyfe Street, IROQUOIS FALLS, ON, P0K-1E0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Paul Chatelain |

To Anson General Hospital, 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 :**

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

**Order / Ordre :**

The licensee must be compliant with s. 30 (1) (3) of the Ontario Regulation 79/10.

Specifically the licensee must:

a) Ensure that the nutrition care and dietary services program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

b) Ensure that the dietary services component of the nutrition care and dietary services program includes menu planning; food production; dining and snack service; and availability of supplies and equipment for food production and dining and snack service.

c) Ensure that the home's Registered Dietitian is involved in the evaluation and revision of the policies and procedures related to the home's nutrition care and dietary services program.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the nutrition care and dietary services program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Section 70 of Ontario Regulation (O. Reg.) 79/10, indicates that the dietary services component of the nutrition care and dietary services program must include: menu planning; food production; dining and snack service; and availability of supplies and equipment for food production and dining and snack service.

Inspector #681 requested the home's policy related to monitoring of residents during meal service from the Support Service Program Lead; however, the Support Service Program Lead was unable to provide Inspector #681 with the document.

Inspector #681 reviewed the home's nutrition care and dietary services program and noted that some of the policies and procedures related to food production, food storage, food safety, sanitization, pureed/minced meals, and thickened fluids had not been reviewed in the past year and that some of these policies

had not been updated since 2008.

During an interview with the Support Services Program Lead, they stated that some of the policies related to dietary services were reviewed by the nutrition managers from the MICs Group in 2016; however, not all of the policies were reviewed or updated at that time. The Support Service Program Lead was unable to provide the Inspector with any documentation related to which policies were reviewed or revised in 2016.

During an interview with RD #101, they stated that they were involved in developing the home's nutrition care policies in 2016 and that these policies were reviewed and revised in 2017. However, RD #101 stated that any of the policies related to food services were developed by the nutrition managers from the MICs Group and that these policies were not developed or reviewed by RD #101. RD #101 stated that they were not aware of any home policy that was related to the following topics: thickened fluids, texture modified diets, monitoring of residents during meals, and monitoring food and fluid intake.

During an interview with the DOC, they stated that they were not aware of any dietary services policies that were reviewed or revised in the past year.

The decision to issue this compliance order was based on the severity, which was determined to be minimal harm or potential for acctual harm and the scope was determined to be widespread. The compliance history identified previous non-compliance related to r. 68 (2) (a) that was issued as a VPC during inspection # 2015_376594_0026 and non-compliance with r. 30 (1) (c) that was issued as a VPC during inspection #2015_376594_0026.
(681)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 15, 2018

**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. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

**Order / Ordre :**

The licensee must be compliant with section 75 (3) of the Ontario Regulation 79/10, and shall ensure that the home's nutrition manager works onsite at the home, in the sole capacity of the nutrition manager for the minimum number of hours per week as outlined in the regulations.

**Grounds / Motifs :**

1. The licensee has failed to ensure that a nutrition manager was on site at the home working in the capacity of nutrition manager for the minimum number of hours per week outlined in the O. Reg. 79/10, without including any hours spent fulfilling other responsibilities.

Section 75 (4) of the O. Reg. 79/10, identified that a home with a licensed bed capacity of 69 beds would require a nutrition manager to be on site and working in the capacity of a nutrition manager for a minimum of 22.1 hours per week.

During an interview with the Support Services Program Lead, they indicated that they were responsible for managing the food service, housekeeping and laundry departments in the home. The Support Services Program Lead stated that they were in the home for approximately four hours per day or 20 hours per week, and they spent the majority of their time managing the food service department. However, the Support Services Program Lead was unable to elaborate further on how they divided their time spent in the home.

Inspector #681 reviewed the job description for the Support Services Program Lead, which indicated that they were responsible for the administration, health and safety, human resources management, and supervision of the Dietary,

Housekeeping, and Laundry departments.

During an interview with the home's accountant, they stated that the Support Services Program Lead was a shared employee between the home and the local hospital. The home's accountant stated that the Support Services Program Lead was funded at the home as a 0.61 full-time equivalent (FTE) and that this was the equivalent of approximately 23 hours per week.

During an interview with the DOC, they acknowledged that the Support Services Program Lead was not meeting the minimum number of hours outlined in the O. Reg. 79/10 when all of their other duties were taken into account. The DOC stated that the Support Services Program Lead was not meeting the minimum number of hours in the home.

Although the home has no previous history of non-compliance, the decision to issue this compliance order was based on the severity, which was determined to be minimal harm or potential for acctual harm and the scope was determined to be widespread.
(681)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 29, 2018

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

**Order / Ordre :**

The licensee must be compliant with section 71 (1) (e) of the Ontario Regulation 79/10, and shall ensure that the home's menu cycle, is approved by the home's Registered Dietitian who is a member of the staff of the home.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the home's menu cycle was approved by a registered dietitian, who was a member of the staff of the home.

During an interview with Inspector #681, RD #101, they indicated that they were responsible for reviewing the home's menu, but that they did not believe that the home's menu had been reviewed or revised in "a while".

Inspector #681 reviewed the home's policy titled "Menu Planning" (LTC-414), last updated December 20, 2016, which indicated that prior to implementation, the menu must be reviewed and approved by a registered dietitian.

During an interview with the Support Services Program Lead, they stated that the current Fall/Winter Menu was implemented in September 2017, and that the home would be putting out a new menu starting in May 2018. The Support Services Program Lead stated that they did not have any documentation to support that the 2016, or 2017, menus were approved by RD #101 and that, based on available documentation, the last time that the home's menu was reviewed by the RD was in April 2015.

The decision to issue this compliance order was based on the severity, which was determined to be minimal harm or potential for acctual harm and the scope was determined to be widespread. The compliance history identified previous non-compliance related to r. 71 (1) (b) that was issued as a VPC during inspection # 2015_376594_0026 and non-compliance with r. 71 (6) that was issued as a VPC during inspection #2015_376594_0026.
(681)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 15, 2018

## 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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  22nd  day of May, 2018**

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

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

**Name of Inspector / Nom de l'inspecteur :** Tiffany Boucher

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