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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 18, 2017	2016_380593_0035	034778-16	Critical Incident System

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD SUITE 301 MISSISSAUGA ON L5N 2X4

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

PERTH COMMUNITY CARE CENTRE
101 CHRISTIE LAKE ROAD R. R. #4 PERTH ON K7H 3C6

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

GILLIAN CHAMBERLIN (593)

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): December 21 - 22, 2016.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nursing Staff, Dietary Staff, Personal Support Workers (PSW), Registered Dietitian (RD) and residents.

The inspector observed the provision of care and services to residents including meal services, staff to resident interactions, residents’ environment, resident health care records and reviewed licensee policies.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
1 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident (CI) was submitted to the Director under the LTCHA related to an incident resulting in the unexpected death of resident #001. It was reported in the CI that resident #001 was coughing and spitting out food during the evening meal service, lost consciousness and attempts made to revive the resident were unsuccessful. The Coroner found that the cause of death was an accident due to asphyxiation.

A review of resident #001's progress notes by Inspector #593, found entries related to the incident:

* Resident #001 received their dinner and shortly after, RPN #105 was called to the dining room as the resident was choking. Staff assisted the resident to spit out what was in their mouth and the resident stopped coughing. The resident was shown back to their seat and less than a minute later, RPN #105 was called again as the resident became unresponsive and their face was turning blue. RPN #105 performed the Heimlich on the resident while they were sitting in their chair with no success. Resident #001 was then lowered to the floor where PSW #102 sat the resident up and continued the Heimlich.

* Resident #001 ambulated out of the dining room-coughing and spitting out food into the garbage assisted by PSW #101 and RPN #105. The resident turned to walk back to their dining chair, their skin was ashen in colour and they collapsed with loss of consciousness into a chair. PSW #102 performed the Heimlich then placed the resident on the floor for chest thrusts. Attempts to revive resident #001 were unsuccessful.

A review of resident #001's care plan, current at the time of the incident, by Inspector #593, found that the resident had multiple interventions documented to ensure a safe swallow including:

• Check for pocketing of foods after each meal
• Provide water with all meals and ensure resident #001 has swallowed all foods to prevent any aspiration
• Provide regular texture but cut up in small pieces
• No fork, only teaspoon as per speech language pathologist (SLP) and registered dietitian (RD) recommendations
• Monitor chewing and swallowing, if any concerns such as difficulty chewing, prolonged chewing, coughing on food or fluids, pocketing or drooling, notify RD
• Remind resident to eat slowly, chew thoroughly and empty their mouth
• Assessment done by SLP- recommended cut up food in small pieces

A review of the health care record for resident #001, found an order from the RD to cut food up in small pieces.

A review of the health care record for resident #001, found an assessment completed by the SLP with the following recommendations:

1. Verbally remind resident #001 to eat slowly before and during every meal
2. Verbally remind resident #001 to take a small sip of liquid at a time
3. Stop resident #001 if they overload their mouth. Get them to empty out mouth. Start again
4. Have resident #001 use a teaspoon size implement to control bolus size
5. Make sure pieces of meat and vegetables are cut into smaller bits

A review of resident #001’s diet roster by Inspector #593, located in the kitchen/dining room of the home, documented that the resident was to receive a regular diet with regular texture.

A review of resident #001’s progress notes by Inspector #593, found multiple entries over a five month period indicating a history with swallowing issues at mealtimes, including regular emesis of undigested food, difficulty swallowing particular foods at mealtimes, pocketing of food at mealtimes, coughing up food at mealtimes and eating very fast at mealtimes without adequate chewing.

During an interview with Inspector #593, December 22, 2016, PSW #100 indicated that she was the PSW serving the food to residents during the evening meal period when the incident occurred. PSW #100 further indicated that she served a plate of food to resident #001 which was not cut up, she went back to the kitchen and was gone for approximately 30 seconds. By the time she returned, the resident was already up and spitting food into the garbage with assistance by PSW #101. Shortly after, resident #001 lost consciousness and multiple staff members were intervening to help the resident, with no success. PSW #100 further indicated that she had been providing care for this resident for approximately one year and this resident had choked on food in the past and had a history of pocketing food. PSW #100 added that the resident also became anxious during meals and was one of the last tables to be served therefore usually ate fast once they received their food. PSW #100 was not aware of any of the interventions documented to manage the choking risk/ swallowing problems with this resident.

During an interview with Inspector #593, December 22, 2016, PSW #102 indicated that

he was in the dining room during the incident. PSW #102 further indicated that he saw resident #001 gagging on their food and then proceeded to spit up a large amount of food into the garbage. PSW #102 indicated that his understanding was that resident #001 was on a regular diet and was able to eat on their own.

During an interview with Inspector #593, December 22, 2016, PSW #101 indicated that she was in the dining room during the incident. PSW #101 further indicated that she assisted resident #001 by urging the resident to spit out the food that was in their mouth, as she could see that they needed help as they were not getting their breath. After this, PSW #101 indicated that resident #001 needed further assistance, which was then given by nursing staff, including the DOC. PSW #101 indicated that resident #001 was prone to choking which was commonly known however during this meal service, they were served the regular textured meal. Resident #001 put a large quantity of the food into their mouth, which they were known to do. PSW #101 further indicated that they had been given no instructions regarding this resident and their choking risk and reported that they were listed as a regular diet on the diet list in the dining room.

During an interview with Inspector #593, December 22, 2016, RPN #105 indicated that she was outside of the dining room with her medication cart when she was called into the dining room as resident #001 was choking on their food. RPN #105 indicated that she was involved in assisting the resident, including performing the Heimlich on resident #001. RPN #105 indicated that the resident was delivered a plate of food which included regular textured items and within 10 seconds, they had put a large quantity of the regular textured food into their mouth. RPN #105 added that resident #001 had a history of pocketing food and then shoving more food into their mouth when their mouth was already full. RPN #105 indicated that resident #001 was on a regular diet and did not require any special interventions during meals that she was aware of.

During an interview with Inspector #593, December 22, 2016, RN #104 indicated that she was in the dining room during the incident. RN #104 further indicated that they saw the resident leave the dining room, go over to the garbage and head back to the dining room which by this time, they were choking. RN #104 indicated that they called a code white, 911, the physician and the resident’s family. During this time, the resident had already passed away and the ambulance had arrived. RN #104 indicated that resident #001 had a history of shovelling food quickly into their mouth as well as pocketing food and to manage this, the SLP recommended that their food was to be cut up into tiny pieces which was the responsibility of the PSWs in the dining room. RN #104 added that this resident also needed cueing to slow down when eating.

During an interview with Inspector #593, December 22, 2016, the RD indicated that resident #001 was referred to her due to eating fast and choking. During the assessment, she told the resident to slow down and they would. The RD further indicated that she did not want to put the resident on a minced diet unless absolutely necessary as there was a balance between quality of life and risk. For a second opinion, she made a referral to the SLP. Interventions as a result of the SLP assessment included cutting the food into small pieces, slowing down while eating, using a teaspoon while eating and clearing food from their mouth before taking another bite. The RD indicated that these interventions were communicated to staff in the care plan and diet lists located in the dining room and servery. The RD added that she was surprised that this incident happened as from her understanding, the resident was not showing many signs of a swallowing issue.

During an interview with Inspector #593, December 22, 2016, DOC #106 indicated that she responded to the incident in the dining room when a code white was called. The DOC added that by the time she arrived to the dining room, the resident was cyanotic and they were placing them into the recovery position. Resident #001 was still making the motion to breathe however they were not taking in any air. Resuscitation was initiated however this was unsuccessful. The DOC reported that the cause of death received from the Coroner was asphyxiation. The DOC indicated that she was aware that this resident was a choking risk and had interventions documented in their care plan to manage this. The DOC added that it was the responsibility of the float PSW to cut up this resident’s food after being served from the kitchen.

During an interview with Inspector #593, December 22, 2016, Food Service Manager (FSM) #107 indicated that for a resident requiring a cut up diet, the dietary staff in the kitchen serve a regular meal and the PSW staff are responsible for cutting up the food at the residents table. Dietary staff would not be aware of this intervention. This process was previously done in the kitchen, however for the residents dignity, they started cutting up the meals at the dining table so that the resident could initially see a regular meal. FSM #107 further indicated that for residents requiring a cut up diet, a regular textured diet was documented on the diet list in the kitchen as the dietary staff were required to serve a regular diet which was then cut up by the PSW staff. The PSW staff should be getting their information from the care plan and the kardex which both documented a finely cut up diet for resident #001. FSM #107 was asked how the PSW staff would know what size to cut the food into when a cut-up diet was ordered, the FSM responded that it is usually bite sized which should be described by the RD in the care plan however the FSM indicated that the description of a cut-up diet was not documented in the policy

related to texture modified diets.

A review of the home's policy "Regular, Therapeutic and Texture Modified Diets- DTY-III-011" dated September 2014, found no description of or documentation related to a cut-up diet.

As documented in resident #001's health care record and confirmed by interviews with staff, resident #001 had a history of pocketing food, eating fast and too much at once and choking/coughing at mealtimes. There were multiple interventions in place to manage this risk, which were documented in the care plan and the kardex. Interventions documented included to cut up food in small pieces and remind the resident to eat slowly, chew thoroughly and empty their mouth. At the time of the incident, resident #001 was served a regular textured meal which had not been cut up, the resident was then allowed the opportunity to put a large quantity of this meal into their mouth, at which they then starting choking on their food. Resident #001 was not provided with foods as per their plan of care. [s. 6. (7)]

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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the accidental and unexpected death of resident #001 was reported to the Director immediately.

A Critical Incident (CI) was submitted to the Director under the LTCHA related to an incident resulting in the unexpected death of resident #001. It was reported in the CI that resident #001 was coughing and spitting out food during the evening meal service, lost consciousness and attempts made to revive the resident were unsuccessful. The Coroner found that the cause of death was an accident due to asphyxiation.

The CI was submitted to the Director approximately three days after the incident occurred.

During an interview with Inspector #593, on December 22, 2016, DOC #106 indicated that she did not call the after-hours pager to immediately report the incident. DOC #106 further indicated that she knew that a CI had to be submitted regarding the incident however was not aware that this incident was required to be immediately reported to the Director. [s. 107. (1)]

Issued on this 20th day of January, 2017

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

Original report signed by the inspector.

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) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2016_380593_0035
Log No. / Registre no:	034778-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 18, 2017
Licensee / Titulaire de permis :	DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC 2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	PERTH COMMUNITY CARE CENTRE 101 CHRISTIE LAKE ROAD, R. R. #4, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Woodcock

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To DIVERSICARE CANADA MANAGEMENT SERVICES CO., 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s. 6 (7) of the LTCHA. This plan is to include:

1. Strategies taken to ensure that all dietary and nursing staff are aware of and have access to dietary related interventions in a residents plan of care.
2. Review and updating of resident diet lists located in the dining rooms and kitchens to include all dietary related interventions for all residents.
3. The licensee shall ensure that all dietary and nursing staff of the long-term care home are provided training on the provision of safe foods and fluids to residents specifically related to texture modified foods and floods, dysphagia and other factors related to choking risk.
4. Review and amendment of policy DTY- III- 011 "Regular, Therapeutic and Texture Modified Diets dated September, 2014 to include a description and procedure for the provision of cut-up diets in the home. The updates to the policy is to be included in the staff training as described above.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be faxed to the inspector's attention at (613) 569-9670 or emailed to the Inspector at OttawaSAO.MOH@Ontario.ca. This plan must be received by February 1, 2017 and fully implemented by March 15, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident (CI) was submitted to the Director under the LTCHA related to an incident resulting in the unexpected death of resident #001. It was reported in the CI that resident #001 was coughing and spitting out food during the evening meal service, lost consciousness and attempts made to revive the resident were unsuccessful. The Coroner found that the cause of death was an accident due to asphyxiation.

A review of resident #001's progress notes by Inspector #593, found entries related to the incident:

* Resident #001 received their dinner and shortly after, RPN #105 was called to the dining room as the resident was choking. Staff assisted the resident to spit out what was in their mouth and the resident stopped coughing. The resident was shown back to their seat and less than a minute later, RPN #105 was called again as the resident became unresponsive and their face was turning blue. RPN #105 performed the Heimlich on the resident while they were sitting in their chair with no success. Resident #001 was then lowered to the floor where PSW #102 sat the resident up and continued the Heimlich.

* Resident #001 ambulated out of the dining room-coughing and spitting out food into the garbage assisted by PSW #101 and RPN #105. The resident turned to walk back to their dining chair, their skin was ashen in colour and they collapsed with loss of consciousness into a chair. PSW #102 performed the Heimlich then placed the resident on the floor for chest thrusts. Attempts to revive resident #001 were unsuccessful.

A review of resident #001's care plan, current at the time of the incident, by Inspector #593, found that the resident had multiple interventions documented to ensure a safe swallow including:

• Check for pocketing of foods after each meal
• Provide water with all meals and ensure resident #001 has swallowed all foods to prevent any aspiration
• Provide regular texture but cut up in small pieces
• No fork, only teaspoon as per speech language pathologist (SLP) and registered dietitian (RD) recommendations
• Monitor chewing and swallowing, if any concerns such as difficulty chewing, prolonged chewing, coughing on food or fluids, pocketing or drooling, notify RD
• Remind resident to eat slowly, chew thoroughly and empty their mouth

• Assessment done by SLP- recommended cut up food in small pieces

A review of the health care record for resident #001, found an order from the RD to cut food up in small pieces.

A review of the health care record for resident #001, found an assessment completed by the SLP with the following recommendations:

1. Verbally remind resident #001 to eat slowly before and during every meal

2. Verbally remind resident #001 to take a small sip of liquid at a time

3. Stop resident #001 if they overload their mouth. Get them to empty out mouth. Start again
4. Have resident #001 use a teaspoon size implement to control bolus size

5. Make sure pieces of meat and vegetables are cut into smaller bits

A review of resident #001's diet roster by Inspector #593, located in the kitchen/dining room of the home, documented that the resident was to receive a regular diet with regular texture.

A review of resident #001's progress notes by Inspector #593, found multiple entries over a five month period indicating a history with swallowing issues at mealtimes, including regular emesis of undigested food, difficulty swallowing particular foods at mealtimes, pocketing of food at mealtimes, coughing up food at mealtimes and eating very fast at mealtimes without adequate chewing.

During an interview with Inspector #593, December 22, 2016, PSW #100 indicated that she was the PSW serving the food to residents during the evening meal period when the incident occurred. PSW #100 further indicated that she served a plate of food to resident #001 which was not cut up, she went back to the kitchen and was gone for approximately 30 seconds. By the time she returned, the resident was already up and spitting food into the garbage with assistance by PSW #101. Shortly after, resident #001 lost consciousness and multiple staff members were intervening to help the resident, with no success. PSW #100 further indicated that she had been providing care for this resident for approximately one year and this resident had choked on food in the past and had a history of pocketing food. PSW #100 added that the resident also became

anxious during meals and was one of the last tables to be served therefore usually ate fast once they received their food. PSW #100 was not aware of any of the interventions documented to manage the choking risk/ swallowing problems with this resident.

During an interview with Inspector #593, December 22, 2016, PSW #102 indicated that he was in the dining room during the incident. PSW #102 further indicated that he saw resident #001 gagging on their food and then proceeded to spit up a large amount of food into the garbage. PSW #102 indicated that his understanding was that resident #001 was on a regular diet and was able to eat on their own.

During an interview with Inspector #593, December 22, 2016, PSW #101 indicated that she was in the dining room during the incident. PSW #101 further indicated that she assisted resident #001 by urging the resident to spit out the food that was in their mouth, as she could see that they needed help as they were not getting their breath. After this, PSW #101 indicated that resident #001 needed further assistance, which was then given by nursing staff, including the DOC. PSW #101 indicated that resident #001 was prone to choking which was commonly known however during this meal service, they were served the regular textured meal. Resident #001 put a large quantity of the food into their mouth, which they were known to do. PSW #101 further indicated that they had been given no instructions regarding this resident and their choking risk and reported that they were listed as a regular diet on the diet list in the dining room.

During an interview with Inspector #593, December 22, 2016, RPN #105 indicated that she was outside of the dining room with her medication cart when she was called into the dining room as resident #001 was choking on their food. RPN #105 indicated that she was involved in assisting the resident, including performing the Heimlich on resident #001. RPN #105 indicated that the resident was delivered a plate of food which included regular textured items and within 10 seconds, they had put a large quantity of the regular textured food into their mouth. RPN #105 added that resident #001 had a history of pocketing food and then shoving more food into their mouth when their mouth was already full. RPN #105 indicated that resident #001 was on a regular diet and did not require any special interventions during meals that she was aware of.

During an interview with Inspector #593, December 22, 2016, RN #104 indicated that she was in the dining room during the incident. RN #104 further indicated

that they saw the resident leave the dining room, go over to the garbage and head back to the dining room which by this time, they were choking. RN #104 indicated that they called a code white, 911, the physician and the resident's family. During this time, the resident had already passed away and the ambulance had arrived. RN #104 indicated that resident #001 had a history of shovelling food quickly into their mouth as well as pocketing food and to manage this, the SLP recommended that their food was to be cut up into tiny pieces which was the responsibility of the PSWs in the dining room. RN #104 added that this resident also needed cueing to slow down when eating.

During an interview with Inspector #593, December 22, 2016, the RD indicated that resident #001 was referred to her due to eating fast and choking. During the assessment, she told the resident to slow down and they would. The RD further indicated that she did not want to put the resident on a minced diet unless absolutely necessary as there was a balance between quality of life and risk. For a second opinion, she made a referral to the SLP. Interventions as a result of the SLP assessment included cutting the food into small pieces, slowing down while eating, using a teaspoon while eating and clearing food from their mouth before taking another bite. The RD indicated that these interventions were communicated to staff in the care plan and diet lists located in the dining room and servery. The RD added that she was surprised that this incident happened as from her understanding, the resident was not showing many signs of a swallowing issue.

During an interview with Inspector #593, December 22, 2016, DOC #106 indicated that she responded to the incident in the dining room when a code white was called. The DOC added that by the time she arrived to the dining room, the resident was cyanotic and they were placing them into the recovery position. Resident #001 was still making the motion to breathe however they were not taking in any air. Resuscitation was initiated however this was unsuccessful. The DOC reported that the cause of death received from the Coroner was asphyxiation. The DOC indicated that she was aware that this resident was a choking risk and had interventions documented in their care plan to manage this. The DOC added that it was the responsibility of the float PSW to cut up this resident's food after being served from the kitchen.

During an interview with Inspector #593, December 22, 2016, Food Service Manager (FSM) #107 indicated that for a resident requiring a cut up diet, the dietary staff in the kitchen serve a regular meal and the PSW staff are

responsible for cutting up the food at the residents table. Dietary staff would not be aware of this intervention. This process was previously done in the kitchen, however for the residents dignity, they started cutting up the meals at the dining table so that the resident could initially see a regular meal. FSM #107 further indicated that for residents requiring a cut up diet, a regular textured diet was documented on the diet list in the kitchen as the dietary staff were required to serve a regular diet which was then cut up by the PSW staff. The PSW staff should be getting their information from the care plan and the kardex which both documented a finely cut up diet for resident #001. FSM #107 was asked how the PSW staff would know what size to cut the food into when a cut-up diet was ordered, the FSM responded that it is usually bite sized which should be described by the RD in the care plan however the FSM indicated that the description of a cut-up diet was not documented in the policy related to texture modified diets.

A review of the home's policy "Regular, Therapeutic and Texture Modified Diets-DTY-III-011" dated September 2014, found no description of or documentation related to a cut-up diet.

As documented in resident #001's health care record and confirmed by interviews with staff, resident #001 had a history of pocketing food, eating fast and too much at once and choking/coughing at mealtimes. There were multiple interventions in place to manage this risk, which were documented in the care plan and the kardex. Interventions documented included to cut up food in small pieces and remind the resident to eat slowly, chew thoroughly and empty their mouth. At the time of the incident, resident #001 was served a regular textured meal which had not been cut up, the resident was then allowed the opportunity to put a large quantity of this meal into their mouth, at which they then starting choking on their food. Resident #001 was not provided with foods as per their plan of care. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2017

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 soins 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 soins 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 18th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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