
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 if the residents' council has advised the licensee of concerns or recommendations the licensee shall within 10 days of receiving the advice, respond to the resident's council in writing, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the food production system, at a minimum, provided for the preparation of all menu items according to the planned menu.

A) The daily production sheet for week 2 Thursday, included puree textured side salad, minced textured marinated vegetable salad and minced textured side salad. It was observed and confirmed by the cook that these menu items were not prepared for the lunch meal June 6, 2013.
B) The daily production sheet for week 2 Monday included puree textured lasagna and california vegetables. It was observed and confirmed by the cook that these menu items were not prepared for the lunch meal June 17, 2013. [s. 72. (2) (d)]

2. The licensee of the long term care home did not ensure that the food production system must, at a minimum, provide for communication to residents and staff of any menu substitutions.

A) The home did not make changes to the posted menus for the lunch meal June 6, 2013. The home replaced pastry puff shells with dinner rolls and replaced watermelon with bananas. [s. 72. (2) (f)]

3. The licensee did not ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

A) The cook confirmed June 20, 2013, that toast was prepared approximately 0710 hours however; extended breakfast service resulted in residents receiving toast that had been sitting prepared in the steam table for an excess of two and a half hours compromising taste and quality. The toast was chewy, soggy-like when tasted by the inspector.
B) The puree textured corn beef was placed in the steam well during the lunch meal June 6, 2013, and the DNS confirmed that it was to be served as a cold menu item. The temperature was not maintained compromising the taste.
C) The puree textured salad was runny and had chunks in it when tasted by the inspector June 17, 2013. The cook confirmed that there were pieces of lettuce in the texture but, indicated it was difficult to puree textures with the current machine. The pureed bread and salad ran into each other when served on the plate compromising the appearance, quality and taste.
D) The puree textured eggs served June 20 and 24, 2013, were not cohesive. The

extended breakfast service resulted in puree eggs sitting in the steam well for an extended period of time which was effecting the quality and appearance of the menu item.
E) The home did not have sufficient quantities of menu items to ensure the planned menu was followed. Staff confirmed that the home did not have sufficient quantities of pears for the lunch meal June 17, 2013, which resulted in the residents who required puree textured diets receiving apple sauce. The home did not have sufficient quantities of puree textured salad prepared for the lunch meal June 17, 2013, resulting in residents who required puree textured diets receiving puree deli meat, bread and applesauce for their entree and puree applesauce for dessert.
F) The home did not always follow standardized recipes. The recipe binder included a recipe for "mellow yellow" soup however, corn chowder soup was prepared. The cook confirmed there was no recipe available at the time preparation. The recipe for puree romaine onion salad was not followed and was noted not to have onion. This was confirmed by the cook. [s. 72. (3) (a)]

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 all food and fluids in the food production system are prepared stored and served using methods to preserve taste, nutritive value, appearance and food quality and that it provides for the preparation of all menu items according to the planned menu, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the home had a dining and snack service that included, at a minimum, review, subject to compliance with subsection 71(6), of meal and snack times by the resident council.

A) The DNS confirmed that a review of the meal times had not been reviewed with the resident's council since the changes in the home's breakfast service was implemented over one year ago. [s. 73. (1) 2.]

2. The licensee of the long term care home did not ensure that the home had a dining and snack service that included, at a minimum, food and fluids that were being served at a temperature that was both safe and palatable.

A) On June 6, 2013, the puree corned beef was placed in the steam well and had a recorded temperature of 33.4 degrees Celsius. The DNS confirmed that the menu item was to be served cold and placed the item on an ice bath. The standardized recipe directed staff to maintain the temperature at four degrees Celsius. [s. 73. (1) 6.]

3. The licensee of the long term care home did not ensure that the home had a dining and snack service that included, at a minimum, providing residents with any eating aids, assistive devices, personal assistance and encouragment required to safely eat and drink as comfortably and independently as possible.

A) The Dining Serving Report indicated that resident #003 was to receive a lipped plate for meals however; the resident received a regular plate for the lunch meal June 17, 2013. The resident was observed trying to eat independently however; when the resident attempted to scoop their puree textured food, the food would slide off the plate onto the table. Staff confirmed that the resident needed a lipped plate. [s. 73. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that food and fluids being served a t a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee had not ensured that the temperature of the water serving all bathtubs, showers and hand basins used by residents was at 49 degrees Celsius or less.

A) On June 12, 2013, water serving hand basins was identified to be warm. At approximately 1140 hours water temperature was recorded as 56.3 degrees Celsius in the bathroom outside of the dining rooms, at 55.4 degrees in the bathroom in room 201 and 55.5 degrees in the bathroom in room 107. Interview with the Director of Environmental Service confirmed that the source temperature was registering high at approximately 56.0 degrees, prior to being adjusted at approximately 1210 hours, to below 49 degrees. [s. 90. (2) (g)]

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 the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The Long Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS system, which required each
resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the Assessment Reference Date (ARD) of the previous assessment and any significant change in resident's condition, either decline or improvement, to be reassessed along with Resident Assessment Protocol (RAPs) by the interdisciplinary care team using the MDS Full assessment by the 14th day following the determination that a significant change in status had occurred. For all other assessments (quarterly, significant change in resident's health status). The care plan must be reviewed by the interdisciplinary team and where necessary revised, within 14 days of the ARD or within seven days maximum following the date of VB2. RAPS must be generated and reviewed and RAPS assessment summaries must be completed for triggered RAPs and non-triggered clinical conditions to which the license is subject for the following identified residents:

A) Resident #409 MDS's coding for dental care and the corresponding RAP was completed twelve days later and the RAP's for mood state and pressure ulcers were completed eleven days after the scheduled ARD.
B) Resident #821 MDS's coding for physical functioning and structural problems and for skin conditions was completed 37 days after the scheduled ARD.
C) Resident #855 RAP's for visual functioning, functional rehab, urinary incontinence and indwelling catheter, mood state, falls, pressure ulcers and psychotropic drug use were not completed until nine days after the scheduled ARD.
D) Resident #819 has had a total of ten RAP's completed, the first RAP was completed 14 days after the scheduled ARD and the last RAP was completed on 22 days later.
E) Resident #812 had not had a RAP completed related to recreation 23 days after the scheduled ARD.
F) The plan of care for resident #812 was due to have been reviewed however; it was noted that a review of the care plan had not yet been completed when reviewed nine days later. The plan of care in the electronic documentation system indicated that the plan of care was overdue for all identified problems. [s. 101. (4)]

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 the practice requirements of the RAI-MDS system are met which are required in the LSAA with the LHIN under the Local Health System Integration Act, 2006, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Not all staff participated in the implementation of the infection prevention and control program.

A) The home had a procedure for the "Cleaning and Disinfecting of Specific Non-Critical Reusable Resident Equipment/Items, ICP-C-10-05". This document required staff to clean hygiene items such as bath and kidney basins and mouth care/denture storage containers weekly and more frequently as needed. Staff are to clean the items after each use and weekly disinfect. A number of kidney basins (rooms 201, 206, 205) and a cup used for mouth care (203) was observed to be soiled with what appeared to be tooth paste and paste residue (white in colour) over a four day period of time, when the supplies were observed by the inspector. [s. 229. (4)]

2. The licensee did not ensure that the following immunization and screening measures were in place for residents to be offered immunization against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A) The DOC was unable to confirm that any residents were offered tetanus and diphtheria upon admission. The home's policy did not include the offering of tetanus and diphtheria and the wellness consent form signed on admission did not include the offering of tetanus and diphtheria. [s. 229. (10) 3.]

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 all staff participate in the implementation of the program and that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The resident-staff communication and response system was not easily used by residents, staff and visitors at all times.

A) The communication system in the bathroom in room 107 was not easy to use on June 7 and 12, 2013. When the quick release green cord was pulled lightly it detached from the portion of the cord which was attached to the wall plate, without activating an alert. The Director of Environmental Services confirmed that the call bell was not functioning as designed and would not easily be used by the resident or staff. [s. 17. (1) (a)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that resident #506 received fingernail care. The resident was observed June 6, 2013, and June 21, 2013, to have soiled fingernails. The resident's plan of care directed staff to provide fingernail care on bath days. Point of Care indicated that the resident last received nail care June 15, 2013. The Point of Care documentation indicated the resident did not receive the scheduled bath including fingernail care on four occasions over the past month. [s. 35. (2)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were fully implemented for the cleaning of the home, including, resident bedroom floors.

A) Bedroom floors in rooms 206 and 212 were not cleaned daily as per the procedure in the home. On June 13 and 14, 2013, the floors were not completely cleaned under the beds in the identified rooms, leaving pieces of paper towels under the beds. Interview with the housekeeper confirmed that each resident room was to have a general tidy each day consisting of: wipe down of tables, railings and the window sills, garbage collection, sweep and wash the floor and cleaning of the bathroom. [s. 87. (2) (a)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home's policies and procedures related to the labeling of residents' clothing was implemented and followed by staff.

A) During interviews with registered staff, personal support worker staff and laundry staff at the home, it was confirmed that when labeling was required for the clothing of a new resident or if newly acquired clothing was brought in by family for a resident, the clothing items were taken to the laundry area, placed on the table in the laundry room and a note was placed on the clothing indicating that they required labeling. Staff interviewed indicated that on occasion, the items of clothing were placed in a plastic bag but this was not the usual process. Usually the clothing was just placed on the table in the laundry room without a bag.
B) The home's policy related to "Personal Clothing Service- Labeling ESP-A-65", dated September 2004, directed the Unit Supervisor or In Charge person to place the clothing in a clear plastic bag, label the bag with the resident's name, room number and date and take it to the laundry room.
C) It was the responsibility of the Unit Manager / designate to list the clothing on the Clothing Inventory Form. This form must then be signed to indicate agreement / receipt of inventory. Laundry staff interviewed indicated that this process was not being routinely followed. [s. 89. (1) (a) (ii)]

2. The licensee did not ensure that the home's policy and procedure related to missing items of clothing was implemented and followed by staff.

A) The homes policy related to "Management of Personal Belongings LTC-B-110" directed staff to initiate a "Client Services response Form" for all missing items and conduct a thorough search and communicate to the Resident/Substitute Decision Maker/ family.
B) During an interview with the Director of Environmental Services, they indicated that there was a list in the laundry area that was completed when an item was reported missing.
C) During an interview with laundry staff, it was confirmed that they were not aware of any formal process for notification of laundry or tracking of lost items provided for laundry staff to use. They also confirmed that there was no documented list in the laundry area of items that were lost. They indicated that staff would usually verbally tell them when something was missing or family members would come to the laundry and report lost items to them. They would then look though closets and the laundry area to try to find the lost items. They were not aware of any formal process for

documentation of missing items or the results of search.
D) The Executive Director indicated that they receive a Client Services Response Form initiated by the staff. The Executive Director indicated that they complete this form but it appeared that there was no formal system to tract lost clothing for nursing or laundry staff to use. [s. 89. (1) (a) (iv)]

WN #28: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was notified no later than one business day after the occurrence of an injury with respect to which a resident is taken to hospital.

A) Resident # 990 sustained a fall that resulted in a transfer to hospital. During an interview with the DOC, it was confirmed that the Director was not notified of the fall and transfer to hospital, nor was a Critical Incident Report submitted within 10 days of becoming aware of the incident. [s. 107. (3) 4.]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that all areas where drugs are stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

A) During a review of the stock storage area, room 146 on the Evergreen Unit, it was noted that this room contained a number of bottles of Milk of Magnesia and Alugel and a number of boxes of Glycerin and Dulcolax suppositories. This room was accessible to all staff. The key to this room was kept on a chain that was hung above the tub room door and any staff or visitor could easily access it at any time. [s. 130. 2.]

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 21st day of August, 2013

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

Tammy Szymanowski

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

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) :	TAMMY SZYMANOWSKI (165), LISA VINK (168), MARILYN TONE (167)
Inspection No. / No de l'inspection :	2013_202165_0010
Log No. / Registre no:	H-000299-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 31, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	TELFER PLACE 245 GRAND RIVER STREET NORTH, PARIS, ON, N3L -3V8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that staff involved in the different aspects of care of residents collaborate with each other in the assessment of the residents so that the assessments are consistent with and complement each other.
The plan shall include:

a) planned actions to ensure that the appropriate staff collaborate with each other in the assessments of residents, in a timely fashion
b) quality management activities that will be implemented to ensure compliance
The plan is to be submitted by September 6, 2013, to tammy.szymanowski@ontario.ca.

Grounds / Motifs :

1. Staff involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were consistent with each other.

Resident #830 was observed to have one short bed rail in the raised position, which was confirmed by PSW staff. The coding during MDS assessment for June 2013, identified that the resident did not use any rails. The Point of Care documentation completed for seven days prior to the assessment identified the

use of the bed rail for turning or repositioning. The RAI Coordinator confirmed that the information recorded on the assessment was an error and not consistent with the needs of the resident. (168)

2. Nursing staff identified that resident #568 had poor daily fluid consumption and sent six referrals to the RD over a three week period. The clinical record indicated that the RD had assessed the resident and documented, that the resident was meeting their fluid requirements and no interventions were needed. Daily fluid intake records over a two week period prior to the assessment, indicated the resident consumed only 55% of their established fluid requirement. The assessment completed by the RD was not integrated and consistent with the resident's needs.
(165)

3. Resident #819 had a MDS assessment completed with in May 2013. Section "J" of the MDS indicated the resident experienced "none of the above" indicators of fluid status which included "insufficient fluid; did not consume all or almost all liquids provided during the last three days" however; a review of the resident's fluid records indicated the resident had poor fluid intake during the three day observation period. The triggered nutritional RAP signed by the RAI Coordinator had not changed from the nutritional RAP completed the previous quarter by the RD . The RD and RAI coordinator confirmed that the RAP did not identify the correct current or previous weight, and that there was no collaboration in the completion of the assessment. (165)

4. Resident #830 had a MDS assessment completed in December 2012. This assessment related to mood and behavioural patterns identified that the resident had behaviours identified up to five days a week, including three different indicators of verbal expressions of distress and one indicator of sad, apathetic or anxious appearance, in addition to two other behavioural symptoms which occurred one to three times in the past seven days. The MDS assessment completed the next quarter, identified a reduction in indicators of verbal expressions of distress to two and no indicators of sad, apathetic or anxious appearance, and a change in the previous specific behavioural symptoms identified, however included the occurrence of a new behaviour. This assessment identified that the resident had no change in mood or behavioural symptoms compared to the status of 90 days ago, which was not consistent with the assessment of December 2012. (168)

5. Resident #085 had a Pressure Ulcer Risk Scale (PURS) score of three for the assessment completed in November 2012. The score increased to five for the next quarterly assessment completed. The Resident Assessment Protocol (RAP) completed for pressure ulcers for the quarterly assessment indicated that the PURS score was unchanged. The increase in the PURS score indicated that the resident was at a higher risk of skin breakdown. The two assessments were not consistent with each other. (168)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 shall ensure that the care set out in the plan of care is provided to all residents, including residents #819, #506, #822, #855, #278, #603, #963 and #807, as specified in their plans of care.

Grounds / Motifs :

1. Resident #807's high nutritional risk plan of care indicated the resident was to receive 125ml prune juice at breakfast and lunch however; the resident was not offered and provided prune juice at breakfast June 20 and June 24, 2013. (165)

2. The nutritional risk plan of care for resident #819 indicated staff were to provide a labeled beverage at snacks. It was observed June 18, 2013, from 0950hrs to 1130hrs when the resident was taken directly to the tub room, that the resident was not offered and provided their labeled beverage for morning snack. The resident was taken directly from the tub room to the dining room and staff confirmed that beverages and nourishments were not distributed for the morning. (165)

3. Resident #807's plan of care for inadequate fluid intake indicated that staff were to provide two labeled snacks at morning nourishment however; this was not provided when observed June 18, 2013. Staff confirmed the morning nourishment cart was not distributed. (165)

4. The licensee did not ensure that the care set out in the plan of care was provided to resident #963 as specified in the plan. Registered staff indicated that the resident had not eaten more than 50% of their meals on six or more occasions in the past three days and as a result a 72 hour food intake study

would be initiated. There was no food intake study initiated and staff interviewed confirmed that they had not completed an intake study for this resident. (165)

5. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) The plan of care for resident #822 identified that the resident requires assistance with toileting and is to be toileted before and after meals and at bedtime. On June 20, 2013, the resident was observed in the dining room from 0813 hours until 1015 hours. Staff interviewed at 1315 hours identified that the resident last toileted at approximately 0830 hours and not again.
B) The plan of care for resident #278 identified that staff are to monitor for identified behaviours. On June 20, 2013, the resident was observed to enter the dining room at 0825 hours and exhibited this behaviour, when no staff were in attendance. Dietary staff were not in constant attendance and nursing staff were not able to come to the dining room until 0852 to assist and supervise residents with eating. The resident was not monitored as per the plan of care.
C) The plan of care for resident #603 identified that the resident required assistance with toileting and was to be toileted before and after meals. On June 20, 2013, the resident was observed entering the dining room at 0829 hours. The resident was removed from the dining room following the breakfast meal at 1100 hours. Staff interviewed at 1315 hours indicated that the resident was last toileted before the breakfast meal. The resident was not toileted as per the plan of care. (168)

6. The Snack Report indicated that resident #855 was to have a labeled beverage at morning snack. On June 12, 2013, the labeled beverage was observed in the basket at the nursing station at 1154 hours. Staff interviewed confirmed that the beverage should have been given to the resident mid morning and removed it from the nurses station. It was identified that it was too close to lunch to offer the beverage, which was now warm to the resident at 1154 hours. (168)

7. A) The plan of care for resident #822 identified under bowel incontinence an intervention to provide 125ml of prune juice at breakfast. On June 20 and 24, 2013, breakfast meal was observed and the resident was not provided with the prune juice as specified in the plan of care.

B) The plan of care for resident #822 identified under modified nutritional risk that the resident was to have a snack and beverage at the morning snack. On June 12, 2013, the labeled snack and beverage were still in the basket at the nursing station at 1154 hours. Staff interviewed confirmed that the snacks should have been given to the resident mid morning and removed them from the nurses station. It was identified that it was too close to lunch to offer the snacks to the resident at 1154 hours. (168)

8. The licensee did not ensure that Resident # 812 was provided care related to toileting as directed in their plan of care.

A) The plan of care for Resident # 812 directed staff to toilet the resident before meals, after meals and at bed time. On June 20, 2013 the resident was not observed to be toileted after breakfast or before lunch. During an interview with personal support worker staff, it was confirmed that the resident had been toileted prior to the breakfast meal and would be toileted after lunch but was not toileted after breakfast or before lunch as was directed in the resident's plan of care. (167)

9. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
A) Resident #506's plan of care for bladder and bowel incontinence identified that staff were to check for wetness ac, pc meals, every evening and on rounds during night. The resident was observed June 20, 2013, from 0841hrs to 1055hrs and was not checked by staff during this time period. Staff interviewed at 1315hrs confirmed that the resident had not been toileted since the resident first got up prior to breakfast.
B) Resident #506's plan of care for high nutritional risk indicated staff were to provide 125ml of prune juice at breakfast daily however; this was not offered and provided during the breakfast meal June 20, 2013.
(165)

10. Documentation in resident #819's clinical health record indicated that a nutritional supplement was initiated by the DNS and an entry by the RD in the progress notes the same day indicated for staff to continue the supplement. The nutritional risk plan of care indicated the resident was to receive a two calorie supplement at specified times. Registered staff confirmed that only registered staff provide the two calorie supplement and that the resident did not receive the

supplement and was not one of the five residents that routinely received a supplement according to the medication administration records (MAR). The RD confirmed there was no written order and was unaware the resident did not routinely receive the supplement since it was ordered three months earlier. The resident had significant weight loss over the past year. (165)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that there is an organized program of nutrition care, dietary services and hydration for the home to meet the daily nutrition and hydration needs of the residents.

The plan shall include how the home will ensure an organized breakfast meal service that allows sufficient time between breakfast and lunch and ensure all residents are offered both a breakfast meal and morning nourishment.

The plan is to be submitted to tammy.szymanowski@ontario.ca by September 6, 2013.

Grounds / Motifs :

1. The licensee did not ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents and organized program of hydration for the home to meet the hydration needs of residents. Breakfast meal service extended over a three hour period when observed June 20, 2013. It was observed throughout the inspection that meal service was extended and staff did confirm this to be a routine service. A staff member was unavailable in the dining room for supervision and assistance with feeding until 0852hrs despite residents already in the dining room at 0813hrs. It was observed and confirmed by staff that a hot breakfast was available until 0930 hours and then muffins/yogurts were available after that time. Only sixteen residents were observed in the dining room by 0930hrs and there was only one psw available to provide assistance during this time. The plan of care for resident #819 indicated that the resident preferred to get up at 0800hrs however; the resident was still in bed at 0950hrs. The resident was deemed at high nutritional risk and was only offered applesauce and one glass of apple juice for the breakfast meal June 24, 2013. Restorative care and a recreation aide did provide assistance on some days however; were unavailable seven days a week to provide additional support. The DNS confirmed that staff use the beverage list to provide beverages to residents preferences and have juice and milk on the beverage cart if someone requests a different beverage. It was observed during the breakfast meal June 20 and 24, 2013, that several residents were only provided one beverage. Staff did not consistently offer additional fluids from the beverage cart. For example, resident #807 deemed at risk for dehydration only received 125ml of apple juice and additional fluids were not offered. Resident #506 received boost supplement 2x 125ml and additional fluids were not offered. Resident #822 received 250ml of milk and additional fluids were not offered. Coffee and tea were not offered to residents during meal service and was only provided if requested by a resident. Meal service was not completed until 1100hrs June 20, 2013, and as result morning beverages and nourishments were not distributed. Observation and staff confirmed that morning beverages and nourishments were not routinely distributed as a result of extended breakfast service. (165)

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).
O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee shall ensure that the registered dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents whenever there is a significant change in a resident's health condition specifically related to the resident's nutritional status, including any risks relating to nutrition, hydration status and any risks relating to hydration including residents #819, #830, #290, #807 and #603.

Grounds / Motifs :

1. The licensee did not ensure that a registered dietitian who was a member of the staff of the home, assesses the matters referred to in paragraphs 13 and 14 of subsection (3).

Registered nursing staff revised the plan of care for resident #830 to include the use of supplements. Interview with the RD, the following day, identified that she became aware of the use of the supplements in preparation for the quarterly assessment that day and that this change in the plan of care was not communicated by nursing staff. The RD did not complete an assessment related to this change in nutritional status when reviewed by the inspector one week later. Interview with the DSM confirmed that they became aware of the use of supplements for this resident from the nursing staff one week later. (168)

2. The licensee did not ensure that a registered dietitian who was a member of the staff of the home, assessed resident's nutritional status, including any risks

relating to nutrition.

A) A dietary requisition was sent to the DNS to trial a textured diet for resident #819. Staff were concerned about the resident's ability to swallow and indicated that the resident had been holding food in their mouth. Review of the resident's clinical health record revealed there was no nutritional assessment completed by the RD when reviewed by the inspector three months later. The resident was observed holding food in their mouth for an extended period of time during the lunch meal June 6, 2013. Staff confirmed that the resident routinely held food in their mouth during meals. The RD confirmed there was no assessment completed related to the resident's swallowing.
B) Registered nursing staff revised the plan of care for resident #830 to include the use of supplements. Interview with the RD, the following day, identified that she became aware of the use of the supplements in preparation for the quarterly assessment that day and that this change in the plan of care was not communicated by nursing staff. The RD did not complete an assessment related to this change in nutritional status when reviewed by the inspector one week later. Interview with the DSM confirmed that they became aware of the use of supplements for this resident from the nursing staff one week later. (165)

3. Resident #290 returned from hospital with a specific diet order. A review of the clinical record indicated that the resident's diet was changed by nursing two days later and five days later the DNS indicated that the resident's fluid consistency was changed and a referral was sent to the RD. On the ninth day the DNS received a diet requisition from nursing to trial a regular texture diet. On the eleventh day the RD indicated in the clinical record that the resident had an unplanned weight loss over the past month and that the resident was currently trialing a regular texture. A nursing progress note two weeks from the residents return from hospital, reported that the resident stated that it hurt to swallow. Review of the resident's clinical health record one month after they returned from hospital revealed there was no nutritional assessment completed by the RD related to the resident's swallowing and diet changes. [s. 26. (4)] (165)

4. Resident #603 had 10 referrals to the RD related to poor fluid consumption over a one month period. Progress notes indicated that the resident did not void for a recent evening shift. The resident's plan of care identified the resident as high nutritional risk and at increased risk for dehydration. Food and fluid records

indicated the resident's intake only met 43% of the resident's established fluid requirements. There was no assessment by the RD of the resident's hydration status and any risks relating to hydration. (165)

5. The plan of care for resident #807 indicated the goal was for the resident to meet their fluid requirements. Nursing staff sent eight referrals to the RD related to poor fluid consumption over a one month period. Food and fluid records over the one week period prior to the RD assessment, indicated the resident only met 35% of their fluid requirements. The RD completed a nutritional quarterly assessment however; there was no assessment of the resident's hydration status and any risks associated with hydration by the RD at that time. The resident was admitted to hospital five days later with a diagnosis of dehydration. [s. 26. (4) (b)] (165)

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licenses shall ensure that all residents in the home are bathed, at a minimum of twice a week by the method of their choice, unless contraindicated by a medical condition. When a resident is not bathed according to the bathing schedule, for reasons other than refusal or absences from the home, the missed bath is to be completed in a timely fashion, to meet the hygiene requirements of the resident.

Grounds / Motifs :

1: Bathing documents confirmed that resident #002 had only received one bath over an 18 day period since they were admitted to the home.
B) Bathing records indicated that 22 residents received only one bath per week and seven residents did not receive any baths over one week. Staff and residents interviewed confirmed that bathing did not occur when the home did not have sufficient staff to fill their staffing complement. It was confirmed that baths were not always made up when missed.
C) Bathing records indicated that 19 residents received only one bath per week and five residents did not receive any baths for over one week.
D) Bathing documents indicated that 17 residents received only one bath per week and three residents did not receive any baths over one week. (165)

2. A)Resident #855 did not have two baths per week each week over a one month period reviewed. Staff confirmed that when baths did not occur in the home it was documented in point of care as "Activity did not occur". This was identified for the second day of the week for the identified weeks. Staff

interviewed stated that the baths were not rescheduled.
B) A review of six resident's Point of Care bathing documentation indicated that the following residents did not receive baths twice a week over a one month period of time reviewed.
i) Resident #990's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur for resident #990 on three occasions over three weeks, as scheduled.
ii) Resident #836's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on three occasions over three weeks, as scheduled.
iii) Resident #031's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on four occasions over four weeks as scheduled.
iv) Resident #364's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on May 29, June 5 and 19, 2013.
v) Resident #409's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on three occasions over three weeks, as scheduled.
vi) Resident #856's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on three occasions over three weeks, as scheduled.
Staff interviewed indicated that they have been told that when they are working short that they should defer baths and that these baths will be caught up later. There was no evidence that these baths were caught up the next day or at any later date.
(167)

3. During a review of the minutes from the Resident's Council Meetings, it was noted that there were concerns expressed by residents that they were not getting their baths in February 2013, and March 2013, related to staff shortages. It was confirmed by the DOC that baths were eliminated when staff shortages occur. [s. 33. (1)] (165)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall ensure that there is a weight monitoring system to measure and record weight on admission and monthly thereafter. The home is to ensure that weights are taken and recorded on a monthly basis for all residents.

Grounds / Motifs :

1. Residents did not have their weights taken and recorded monthly on a routine basis. The Restorative aide confirmed that monthly weights were taken by staff and then recorded in point click care when completed. The following residents did not have the following monthly weights taken and recorded in Point Click Care: resident #542 and #807 did not have February 2013, resident #446, #221, #852 and #005 did not have May 2013, resident #836, #995 and #409 did not have March 2013, resident #855 did not have January 2013, and resident #990 did not have January, March, April or May 2013. The RD confirmed that monthly weights were not always taken and recorded. (165)

2. The licensee of the long term care home did not ensure that the nutritional care program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter. Resident #446 did not have a monthly weight taken and recorded for the month of May 2013. The RD confirmed there was no weight taken and recorded on the 2013 resident weight record or Point Click Care. (165)

3. The licensee of the long term care home did not ensure that the nutritional care program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter. Resident #819 did not have a monthly weight taken and recorded for the month of May 2013. The RD confirmed there was no weight taken and recorded on the 2013 resident weight record or Point Click Care. (165)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. 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.

Order / Ordre :

The licensee shall ensure that residents, with weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated for significant weight changes and any other weight change that compromises the resident's health status; including resident #819.

Grounds / Motifs :

1. The licensee of the long term care home did not ensure that residents with weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated for a change of five per cent of body weight, or more, over one month. A change of ten per cent of body weight, or more, over six months. Any other weight change that compromises the resident's health status.
Resident # 819 experienced a significant weight loss of 7.6% change over 3 months in May 2012. The resident's weight fell below their ideal body weight range established by the RD the following month. The resident's weight continued to decline and triggered a significant weight loss on three more occasions in 2012 with two significant weight losses triggering over six months and one significant weight loss triggering over one month and one significant weight loss triggering over one month in 2013. The resident was reviewed quarterly by the RD in September and December 2012, however; no action was taken despite the resident's continued weight loss. The RAP completed by the RD February 2013, indicated the resident had a gradual weight loss however; weight records indicated that the resident had experienced a significant unplanned weight loss over the past year. Action was not taken by the RD to prevent further weight decline. Point Click Care indicated the resident has continued to loose weight since the quarterly review. There were no referrals initiated and the RD confirmed that significant weight loss had occurred however; there was no assessment completed using an interdisciplinary approach that included actions taken and outcomes evaluated related to the resident's weight changes. [s. 69.] (165)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that all residents are offered a between meal beverage in the morning and afternoon and a beverage in the evening after supper.

The plan shall include how the home will ensure that residents are offered between meal beverages on a continual basis to ensure compliance is maintained.

The plan is to be submitted to tammy.szymanowski@ontario.ca by September 6, 2013.

Grounds / Motifs :

1. The licensee did not ensure that each resident was offered a minimum of a between-meal beverage in the morning.

On June 13, 2013, resident #003 was observed not to be offered a between meal beverage in the morning. The documentation of the resident's intake at snacks for the between meal morning beverage was not completed for June 13, 2013. (168)

2. The licensee did not ensure that each resident was offered a minimum of a between-meal beverage in the morning. It was observed and confirmed by the staff that on multiple days of the review the morning nourishment cart was not distributed to residents. It was observed that some residents do not leave the dining room from breakfast until 1100hrs or later which did not allow sufficient time between breakfast and lunch to distribute the nourishments. It was observed June 18, 2013, from 0950hrs to 1200hrs that the nourishment cart was not distributed and that four observed residents were not offered beverages. This was confirmed by staff. (165)

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

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the planned menu items are offered and available at each meal and snack for all diets and textures.

Grounds / Motifs :

1. A) The planned menu week 1 Monday included sliced pears. It was observed that puree textured pears was not offered during the lunch meal June 17, 2013. Staff confirmed that the menu item was not available. (165)

2. A) The planned menu for week 2 Thursday included puree textured side salad, minced textured marinated vegetable salad and minced textured side salad. It was observed that these menu items were not offered and available during the lunch meal June 6, 2013. This was confirmed by the cook and resulted in residents that required minced texture being served puree textured vegetables.
B) The planned menu for week 2 Thursday included watermelon however, staff and the DNS confirmed this was not offered and available during the lunch meal June 6, 2013 resulting in no alternative dessert choice for resident's who received puree textured diets.
C) The planned menu for week 2 Monday included puree textured lasagna and california vegetables. It was observed that these menu items were not offered and available during the lunch meal June 17, 2013. This was confirmed by the cook and resulted in no alternative entree and vegetable choice for resident's who received puree textured diets.
D) The planned menu week 2 Thursday indicated that 2 #8 scoops of puree textured vegetable stew was to be served however, a #16 scoop was used instead which resulted in smaller quantities being served during the lunch meal June 6, 2013.

E) The planned menu week 1 Monday indicated that a #8 scoop of puree textured assorted deli meat was to be served however; a #12 scoop was used instead which resulted in smaller quantities being served during the lunch meal June 17, 2013.
F) The planned menu week 1 Thursday included stewed prunes. It was observed that this menu item was not offered during the breakfast meal June 20, 2013.
G) The planned menu week 2 Monday included sliced pears. It was observed that this menu item was not offered during the breakfast meal June 24, 2013. (165)

3. The licensee did not ensure that the planned menu items were offered and available at each snack. The nourishment menu for week 2 Wednesday indicated that residents were to be offered carrot loaf however; this was not available and offered June 26, 2013, for the afternoon nourishment pass. (165)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board 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.

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 31st day of July, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TAMMY SZYMANOWSKI

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