Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
July 21, 22, 23, 26, 27 and 28, 2010	2010_107_1500_20Jul141501 2010_127_1500_20Jul160521 2010_147_1500_26Jul102910 2010_167_1500_20Jul124114 2010_171_1500_20Jul141510	Follow Up Inspection H-01910

Licensee/Titulaire

1508669 Ontario Limited
c/o Deloitte & Touche Inc. - 181 Bay Street Brookfield Place, Suite 1400, Toronto, ON M5J 2V1
Fax: 416-601-6690

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

West Park Health Centre, 103 Pelham Road, St. Catharines, ON L2S 1S9

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

Michelle Warrener - LTC Homes Inspector - Dietary - # 107

Elisa Wilson - LTC Homes Inspector - Dietary - # 171

Marilyn Tone - LTC Homes Inspector - Nursing - # 167

Laleh Newell - LTC Homes Inspector - Nursing - # 147

Richard Hayden - LTC Homes Inspector - Environmental Health - # 127

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up inspection in respect of the following previously identified non-compliance:

Follow-up Inspection May 25, 2010
NHA, R.S.O. 1990, Ch N7, Sec 5(2); NHA, R.S.O. 1990, Reg. 832, Section 29; and O2.9

Follow-up Inspection April 7, 2010
NHA, R.S.O. 1990, Ch N7, Sec 5(2); NHA, R.S.O. 1990, Reg. 832, Section 29; and O2.9

Follow-up Inspection June 21-26, 2010
NHA, R.S.O. 1990, Ch N7, Sec 20.10 related to un-met criteria B1.2, B2.4, B3.23, B3.24

Follow-up Inspection January 7, 2010
NHA, R.S.O. 1990, Reg. 832, Section 75(4) related to un-met criterion P1.4

Follow-up Inspection July 7,8,10.15.17, 2009
B1.6, B3.32

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Nutrition Manager, Environmental Services Manager, Clinical Dietitian, front line nursing staff (RPN, RN, PSWs) on the first and second floor, Dietary Aides, and Residents.

During the course of the inspection, the inspectors:
Reviewed health care records, reviewed policy and procedures, observed meal service, observed care, toured the home, and observed staff in routine duties.

The following Inspection Protocols were used during this inspection:

- Nutrition and Hydration
- Continence Care and Bowel Management
- Food Quality Inspection
- Dining Observation Inspection
- Personal Support Services
- Accommodation Services - Maintenance
- Safe and Secure Home

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

18 WN
9 VPC
3 CO: CO #s 001, 002 and 003.

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN#1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.5.
Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Findings:

July 21, 2010:

1. The courtyard/garden gate leading to a concrete staircase was not latched or securely closed. A new fence was installed and the gate latch was not replaced. Residents have access to this unsecured gate and the concrete staircase while in the courtyard/garden. A wheelchair could topple down the staircase or a resident may exit the property.
2. Four wardrobes were not secure and posed tipping hazards in two identified resident rooms.
3. The flooring transition strip was lifted at the entrance to an identified resident room, creating a trip hazard.
4. The placement of tables in the second floor dining room was unsafe at the dinner meal. The table placement caused congestion in the main walkway through the dining room to the left of the steam table. Staff could not walk straight through with trays of food, nor could residents get through with wheelchairs or walkers.

July 22, 2010:

1. Slip and fall hazards due to the loose toilet seats were identified in eight washrooms.
2. Slip and fall hazard due to a toilet not being secured to the floor in a washroom. The toilet rocked back and forth on its base.

Inspector ID #:	#127, #171

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6 (1) (c).
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. The plan of care for an identified resident provides conflicting information related to Advance Directives. The progress notes indicate Advance Directives were signed as Level 1 by the Power of Attorney in May, 2010, however, the plan of care indicates Level 3.
2. The plan of care for an identified resident does not provide clear direction to staff and others who provide direct care to the resident. Several different versions of the plan of care were identified and each version described a different level of intervention required. It was not clear which version was the most current.
3. The dietitian changed an identified resident's diet to regular with specialized restrictions in July, 2010 but the Dining Service Report still showed the previous diet at the time of this visit July 22, 2010. There were no directions for staff regarding the provision of the specialized diet. It is also documented in the plan of care to provide diabetic interventions but no details as to how that instruction relates to foodservice.
4. The plan of care does not provide clear direction to the staff related to an identified resident's one sided weakness as this is needed for safe transferring and positioning.
5. No plan of care was found for an identified resident to indicate an assessment had been completed related to the resident's sleep patterns and preferences. As a result this did not provide clear directions for the staff providing care.

Inspector ID #:	#107, #171, #147

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 with the plan of care providing clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 6 (4) (b).
The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(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.

Findings:

1. The nutritional assessment and plan of care for an identified resident are not consistent with each other. The nutritional assessment completed by the in-house Registered Dietitian identifies that the resident requires a menu that is restricted in a particular nutrient. The menu provided to the resident was developed by the Corporate Registered Dietitian and is not consistent with the resident's assessed requirements. The nutrient analysis, for the menu the resident is currently receiving, identifies the resident is receiving quantities of the restricted nutrient that are 48-52% higher than the resident's requirements. The resident has experienced weight gain this quarter.

Inspector ID #:	#107

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 with ensuring that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with 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.

Findings:

The care set out in the plan of care was not always provided to residents at the lunch meal July 21, 2010:

1. Four identified residents did not have their prescribed nutritional supplement provided.
2. Specific items required for a specialized menu were available, however, were not offered/provided to residents requiring the menu, resulting in five residents receiving items contrary to their prescribed diet order.
3. Three identified residents did not receive specialized items identified on their plans of care and/or received items that are identified as dislikes.

The care set out in the plan of care was not always provided to residents at the lunch meal July 26, 2010:

1. In discussion with the Registered Practical Nurse (RPN) it was noted that three residents were given the incorrect nutritional supplement. The supplement formulation provided to the residents was not consistent with the physician ordered supplements. The supplements provided were not of equivalent nutritional value, resulting in the residents being provided fewer calories than their prescribed order. The residents are at nutrition risk.
2. An identified resident had left the dining room without being provided the ordered nutritional supplement.
3. An identified resident requiring a specialized menu received an item that was contrary to their prescribed menu plan.

The care set out in the plan of care was not provided to the following residents as specified in the plan:

1. The plan of care set out for an identified resident indicates that the resident's bathing preference is for showers, however, the flow sheet for July 2010 indicates that the resident has been receiving tub baths and bed baths.
2. The plan of care set out for an identified resident indicates that the resident's bathing preference is for tub baths, however, the flow sheet for the month of July 2010 indicates that the resident received three tub baths and three showers to date.
3. The plan of care set out for an identified resident indicates that the resident's bathing preference is for tub baths, however, the flow sheet for the month of July 2010 indicates that the resident has received seven showers to date.

Inspector ID #:	#107, #147

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 6. (8).
The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Findings:

1. The nutritional plan of care for an identified resident is stored on the computer, however, the plan is not available / accessible for staff and others who provide direct are to the resident. Front line staff does not have access to the computer and the plan was not printed.
2. The nutrition section of the plan of care for an identified resident was not accessible to staff. The plan was stored in the computer, which is not accessible to front line staff providing care. The nutrition section was not included in the printed summary of the plan of care, which was accessible to staff.

Inspector ID #:	#107, #171

WN #6: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 6. (10) (b) and (c).
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective.

Findings:

1. An identified resident was not reassessed and the plan of care reviewed and revised when there was a significant decline in the resident's hydration status. The resident has been consistently consuming less fluid than their assessed requirements in a 9 day period in July, 2010; however, documentation in the resident's record does not indicate an assessment of the decrease in hydration or a referral to the Registered Dietitian. The resident did not meet their hydration requirement on eight out of nine days reviewed.
2. The plan of care for an identified resident was not revised when the resident's care needs changed in relation to skin integrity. The plan for skin integrity does not reflect the current status of the resident (now has an open area/wound), resulting in unclear direction for staff providing care.
3. The most current plan of care for an identified resident does not reflect the current status of the resident's wound. Documentation in the progress notes indicates that the wound has worsened but the plan of care has not been updated to reflect this change.
4. For an identified resident, the nutritional plan of care was not revised to reflect the resident's current status. The nutritional plan of care for the identified resident directs staff provide a specific intervention related to hyperglycemia but this intervention had been discontinued by the resident's physician.
5. An identified resident sustained a number of falls within a specified timeframe. The plan of care related to falls risk for the identified resident was not effective in the prevention of these falls. The plan of care was not reviewed or revised to address this concern.
6. An identified resident was not reassessed following a change in care needs. The last Dietitian's note was in May indicating the need for a test to determine potential diet changes and a follow-up to be done in a week's time. The test was completed. A follow-up assessment by the Dietitian has not been completed and there is no Dietitian consult regarding the results of the testing.

Inspector ID #:	#107, #167, #171

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 with ensuring that residents are reassessed and the plan of care reviewed and revised when the residents' care needs change, care set out in the plan is no longer necessary, or the care set out in the plan has not been effective, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15. (2)(c).
Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Findings:

July 21 2010

1. The door hinge at the top an identified resident's wardrobe was not attached.
2. The wall surrounding the bathtub in an identified resident's washroom was damaged; paint was cracked and the wall board has deteriorated.
3. The toilet was cracked at its base in an identified washroom.
4. Tub Room 21 – The interior surface of the bathtub was peeling around the drain. The bathtub could not be properly cleaned and disinfected.

Inspector ID #:	#127

WN #8: The Licensee has failed to comply with O. Reg. 79/10, s. 8 (1) (b).

Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(b) is complied with.

Findings:

1. The Home's policy and procedure number NM-II-D020 related to diabetic monitoring was not followed for an identified resident as evidenced by the following examples:
   a. The identified resident was noted to have a high capillary blood glucose reading. Documentation in the resident's progress notes indicates that when the capillary blood glucose reading was rechecked it was even higher. There was no documentation found to indicate that the resident's blood glucose reading was checked again nor was there documentation to indicate that the physician and family/SDM were notified as per the home's policy number NM-II-D020.
   b. The identified resident's capillary blood glucose reading was noted to be high. It is documented that water was given and that the resident's blood glucose level was checked again at an unknown time and was found to be even higher. No further documentation was found related to follow up as per the home's policy NM-II-D020.
   c. The identified resident's capillary blood glucose reading was noted to be high at lunchtime. The resident was offered fluids but no other intervention took place as per the home's policy NM-II-D020.
2. The planned portion sizes were not always followed by staff portioning the lunch meal July 21, 2010 in the first floor dining room. The planned menu for the pureed citrus spring salad states #12 scoop - #10 was used (larger scoop was used). The planned menu for the pureed salmon sandwich states #8 scoop - # 12 was used (smaller scoop was used). Inconsistencies in portion size will result in variation in the nutritional value of the meal in comparison to the planned menu.

Inspector ID #:	#167, #107

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 with following the Home's policies

and procedures, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O. Reg. 79/10, s. 9.1. i and ii
Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home must be,
   i. kept closed and locked,
   ii. equipped with a door access control system that is kept on at all times

Findings:

July 21 2010
1. The door leading to the courtyard/garden from the 1st floor lounge was not closed, locked or alarmed. The gates leading from the courtyard/garden were not secured and allowed a resident to exit the property without staff knowledge.

Inspector ID #:	#127

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 with ensuring that all doors leading to stairways and the outside of the home are kept closed and locked and equipped with a door access control system that is kept on at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O. Reg. 79/10, s. 13.
Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Findings:

July 21 2010
1. The privacy curtains do not fully enclose the residents' beds in three resident rooms. More than one wardrobe was located inside the privacy curtained areas in these resident rooms. Therefore, residents wishing to access their wardrobes would have to enter the privacy curtained area of the other resident, compromising that resident's privacy.

Inspector ID #:	#127

WN #11: The Licensee has failed to comply with O. Reg. 79/10, s. 26 (3) 13.
A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care.

Findings:
1. The plan of care interventions are not always based on a full nutrition assessment. An identified resident had a diet change from one therapeutic diet to another, however a complete nutritional assessment was not documented. There was no assessment of the resident's nutritional status in relation to weight gain, supplement use, nutritional laboratory tests or status of wound.

Inspector ID #:	#171

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 with ensuring there is an interdisciplinary assessment of nutritional status, including height, weight and any risks relating to nutrition care, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O. Reg. 79/10, s. 30 (2).
The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Findings:

1. Review of the 1st floor Treatment Administration Records for July 2010 - Six residents were identified as not having their treatment plan as ordered by the physician, signed off by the registered staff.

2. Review of the 2nd floor Treatment Administration Records for July 2010 - Two residents were identified as not having their treatment plan as ordered by the physician, signed off by the registered staff.

Inspector ID #:	#147

WN #13: The Licensee has failed to comply with O. Reg. 79/10, s. 69.1.
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.

Findings:

1. An identified resident had a documented 9.5% weight loss for the month of July, 2010 and documentation in the resident's record did not reflect that the significant weight loss had been assessed (as of July 21, 2010) or action taken. A re-weigh (to verify the accuracy of the significant weight change) had not been completed.
2. An identified resident had a recorded 10% weight loss for the month of July, 2010. An assessment of the significant weight change has not been completed by the multidisciplinary team (as of July 21, 2010) and a referral to the Registered Dietitian has not been documented.
3. An identified resident had a documented weight loss of 11% in July, 2010. An initial assessment of the weight change was not completed by the multidisciplinary team and a referral to the Registered Dietitian was not completed (as of July 21, 2010). Action was not taken to address the weight change.
4. An identified resident had a significant weight gain of 8% in July, 2010, however, there were no assessments of this change documented and no referral to the dietitian regarding weight gain.
5. An identified resident had a 10% weight loss in one month recorded in July, 2010 with no progress notes, assessments or a referral to the dietitian noted since that time to address the weight loss.

Inspector ID #:	#107, #171

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with O. Reg. 79/10, s. 71 (5).
The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle.

Findings:

1. An individualized menu was not developed for an identified resident who required a specialized menu. Direction is not provided for staff portioning meals and a menu plan is not in place to ensure adequate variety and nutritional value if substitutions are required due to the nutritional restrictions.

Inspector ID #:	#171

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 with developing an individualized menu for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O. Reg. 79/10, s. 73 (1) 5. and 9.
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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
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.

Findings:

1. The Home has a process for providing information to food service workers and other staff assisting residents are aware of residents' diets, special needs, and preferences, however, the process was not followed in a timely manner, resulting in current information not being available to provide direction to staff for the following residents: An identified resident had their diet order changed by the physician on July 19/10, however, the July 21, 2010 supper dining room serving list had not been updated with the new diet order. An identified resident had their diet order changed by the physician on July 19/10, however, the July 21, 2010 lunch and supper dining room serving list were not updated to reflect the current diet. The resident received the wrong diet texture at the lunch meal July 21, 2010.
2. Staff did not have clear direction regarding dietary needs for an identified resident at lunch on July 21, 2010 as this resident did not appear on the Dining Serving Report list.
3. An identified resident did not receive the required level of assistance with eating to safely eat and drink as comfortably and independently as possible at the lunch meal July 21, 2010. Numerous staff were observed assisting the resident intermittently and staff were up and down frequently, interrupting the dining experience for the resident.
4. An identified resident did not receive a lipped plate (as required in their plan of care to promote independence with eating) at the lunch meal July 21, 2010.
5. An identified resident did not receive the required level of encouragement with eating. The resident left at least 50% of both lunch and dinner uneaten on July 21, 2010, and left the table without redirection to the task of eating. The plan of care states the resident may get distracted or leave the table and is to be redirected to the task of eating, which did not occur. This resident has had a significant weight loss recorded in July, 2010.
6. The plan of care for an identified resident indicates a requirement for assistive devices at meals to

assist the resident with eating safely, comfortably and as independently as possible. On July 21, 2010 at lunch and dinner the resident did not receive the required assistive devices.

Inspector ID #:	#107, #171

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 with ensuring a process is in place to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, and to ensure any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortable and independently as possible, are provided to residents, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O. Reg. 79/10, s. 91.

Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

Findings:

July 21 2010

1. An identified resident had two spray bottles of *Tana All-Protector* stored in their wardrobe. The label indicated the product was flammable, poisonous and explosive.

Inspector ID #:	#127

WN #17: The Licensee has failed to comply with O. Reg. 79/10, s. 131 (2)

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Findings:

1. Two identified residents had no bowel movement for 4 consecutive days in July, 2010. The residents did not receive 30mls of Milk of Magnesia on day three or Dulcolax Suppository on day four as per Doctor's signed Medical Directive.
2. An identified resident had no bowel movement for 6 consecutive days in July, 2010. The resident did not receive 30mls of Milk of Magnesia on day three or Dulcolax Suppository on day four or fleet enema on day five as per Doctor's signed Medical Directive.

Inspector ID #:	#147

WN #18: The Licensee has failed to comply with O. Reg. 79/10, s. 231 (a) and (b).

Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times.

Findings:

1. An identified resident did not have their written record maintained and kept up to date. The food and fluid intake record was not dated (maintained) for the month of July 2010.

2. An identified resident did not have their written record kept up to date at all times. Food and fluid consumption was not documented for the lunch meal July 21, 2010 when referenced by the inspector on July 22, 2010. The resident is at nutritional risk.

Inspector ID #:	#107

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 with ensuring a written record is created and maintained for each resident of the home and that the resident's written record is kept up to date at all times, to be implemented voluntarily.

CORRECTED NON-COMPLIANCE
Non-respects à Corrigé

REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
NHA, R.S.O. 1990, Reg 832, Section 75(4) related to un-met criterion P1.4			75. (1) Every administrator shall ensure that, (4) The same foods shall not be served in the same form on the same day, or on consecutive days nor shall the same food in the same form be served on the same day of consecutive weeks except where a majority of the residents indicate the contrary to the administrator. R.R.O. 1990, Reg. 832, s. 75 (4).	#107
NHA, R.R.O. 1990, Reg. 832, s.29			29. Every nursing home shall have the following minimum levels of illumination: 1. 215.28 lux continuous lighting in all corridors.	#127

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). October 12, 2010

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

Name of Inspector:	Michelle Warrener	**Inspector ID #**	107
Inspection Report #:	2010_107_1500_20Jul141501 2010_127_1500_20Jul160521 2010_147_1500_26Jul102910 2010_167_1500_20Jul124114 2010_171_1500_20Jul141510		
Type of Inspection:	Follow Up		
Licensee:	1508669 Ontario Limited c/o Deloitte & Touche Inc. 181 Bay Street Brookfield Place, Suite 1400 Toronto ON M5J 2V1		
LTC Home:	West Park Health Centre 103 Pelham Street St. Catherine's, ON L2S 1S9		
Name of Administrator:	Marjorie Mossman		

To 1508669 Ontario Limited, you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
LTCHA, 2007, S.O. 2007, c. 8, s. 5.
Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Order:
The licensee shall:

1. Secure the gates of the courtyard/garden and keep them secure at all times such that residents may not exit the property from that area.
2. Stabilize and tether to the wall all wardrobes in identified resident rooms to eliminate the risk of the wardrobes tipping over.

3. Repair the transition strip at the entrance to an identified resident room such that it sits flush and no longer poses a trip hazard.
4. Repair, or replace as necessary, the toilet seats in identified resident rooms such that the toilet seats do not slip in any direction and cause any resident to slip and fall.
5. Secure the toilet to the floor in Washroom 24 such that it does not rock back and forth in any direction and cause any resident to slip and fall.

Grounds:

21 July 2010

1. The courtyard/garden gate leading to a concrete staircase was not latched or securely closed.
2. Four wardrobes were not secure and posed tipping hazards.
3. The flooring transition strip was lifted at the entrance to a resident's room.

22 July 2010

1. Slip and fall hazards due to the loose toilet seats in eight areas.
2. Slip and fall hazard due to a toilet not being secured to the floor.

This order must be complied with by:	15 November 2010

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:

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.

Order:

The licensee shall prepare, submit and implement a written plan for achieving compliance to meet the requirement that the care set out in the plan of care is provided to the resident as specified in the plan. The plan is to be submitted to Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton ON L8P 4Y7, Fax 905-546-8255.

Grounds:

The care set out in the plan of care was not always provided to residents at the lunch meal July 21, 2010:

1. Three residents did not have their prescribed nutritional supplement provided.
2. Specific menu items required for the renal menu were available, however, were not offered/provided to residents requiring the menu, resulting in residents receiving items contrary to their prescribed diet order for five residents.
3. One resident did not receive interventions identified on the plan of care to address constipation and hydration.
4. Two residents did not receive the preferred items identified on the plan of care.

The care set out in the plan of care was not always provided to residents at the lunch meal July 26, 2010:

1. In discussion with the RPN it was noted that three residents were given the incorrect nutritional supplement. The supplement formulations are not of equivalent nutritional value, resulting in the residents being provided fewer calories than their prescribed order. The residents are at nutrition risk.
2. One resident had left the dining room without being provided the ordered nutritional supplement.
3. One resident received items that were not allowed on the planned menu due to nutritional restrictions.

The care set out in the plan of care was not provided to the following residents as specified in the plan:
1. Three residents did not receive their preferred bathing preference as indicated on their plans of care.

This order must be complied with by:	26 October 2010

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O. Reg. 79/10, s. 69.1
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.

Order:
The Licensee shall review all residents including the five identified and any resident who experiences a weight changes as defined by 69.1 shall be immediately assessed with interdisciplinary actions taken and outcomes evaluated as appropriate.

Grounds:

1. Five identified residents with significant weight changes were not immediately assessed with interdisciplinary actions taken and outcomes evaluated.

This order must be complied with by:	26 October 2010

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed 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, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 12 day of October, 2010.	
Signature of Inspector:	M Warrener
Name of Inspector:	Michelle Warrener
Service Area Office:	Hamilton Service Area Office