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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 21, 2014	2014_188168_0013	H-000551-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8, STONEY CREEK, ON, L8G-1G6

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

ARBOUR CREEK LONG-TERM CARE CENTRE
2717 KING STREET EAST, HAMILTON, ON, L8G-1J3

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

LISA VINK (168), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), JENNIFER ROBERTS (582), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 8, 9, 12, 13, 14, and 15, 2014.

This inspection was conducted concurrently with Complaint Inspection, log number H-000301-14 and Follow Up inspections log numbers H-000307-14, H-000308-14, H-000884-13, and H-000885-13. This inspection report contains findings of non-compliance related to the concurrent inspections conducted.

During the course of the inspection, the inspector(s) spoke with the interim Administrator, interim Director of Care (DOC), Food Service Manager (FSM), cooks, dietary aides, registered staff, Maintenance Supervisor (MS), housekeeping staff, Restorative Care Aides (RCA), registered nursing staff, Personal Support Workers (PSW's), the Director of Recreation and Leisure, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home and reviewed relevant documents including but not limited to: policies and procedures, clinical health records, menus and productions sheets, and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The written plan of care for each resident did not set out the planned care for the resident.

A. Resident #51 was assessed and admitted to the walking program by the RCA. The plan of care reviewed on May 15, 2014, did not include the planned care for the resident, specifically the implementation of the walking program. Interview with staff confirmed that it was the responsibility of registered staff to record the walking program in the plan of care and that it was not included in the plan.
B. Resident #17 had a Heat Risk Assessment completed in 2013, which identified the resident at high risk. The plan of care reviewed on May 15, 2014, did not include a focus statement related to the assessment completed. Interview with registered staff confirmed that it was the expectation that the plan include the planned care for the resident to be utilized in the event of uncontrolled heat.
C. Resident #19 had a Heat Risk Assessment completed in 2013, which identified the resident at moderate risk. The plan of care reviewed on May 15, 2014, did not include a focus statement related to the assessment completed. Interview with registered staff confirmed that it was the expectation that the plan include the planned care for the resident to be utilized in the event of uncontrolled heat. [s. 6. (1) (a)]

2. 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 #43 indicated that they were to have small portions at mealtimes. During lunch on May 8, 2014, the resident was served a full portion. Interview with staff confirmed that the resident did not receive the serving specified in the plan of care. (528)
B. The plan of care for resident #44 indicated they were to receive a regular diet, regular texture, with meat cut up. During lunch on May 8, 2014, the resident was served a hamburger on a bun. Interview with staff confirmed that the hamburger patty was not cut up as specified in the plan of care. (528)
C. The plan of care for resident #62 indicated that they were to be provided with double portions at all meals as per request. During the lunch meal on May 13, 2014, the resident was provided with regular portions. (585)
D. The plan of care for resident #63 indicated that they were to be provided with a small diet (half portions) as per the therapeutic menu. The resident was identified on the plan to be a small eater. During the lunch meal on May 13, 2014, the resident was provided with regular portions. (585)
E. The plan of care for resident #64 indicated that they were to be provided with a small diet (half portions) as per the therapeutic menu. During the lunch meal on May 13, 2014, the resident was provided with regular portions. (585)
F. The plan of care for resident #65 indicated that they were to be provided with a modified diabetic diet, minced texture and pureed meat. During the lunch meal on May 13, 2014, the resident was provided with regular soup. It was observed and verbalized by a PSW that the soup had large chunks of meat, carrots and noodles in it. (156)
G. The plan of care for resident #70 indicated that they were to be provided with a small diet (half portions), regular texture. During the lunch meal on May 14, 2014, the resident was provided with a regular portion of vegetables (parsnip). (585)
H. The plan of care for resident #71 indicated that they were to be provided with an energy controlled, puree diet. During the lunch meal on May 14, 2014, the resident was provided a regular sized portion of puree bread, which was a larger portion than the plan directed. (585)
I. The plan of care for resident #61 indicated to provide a small diet (half portions), regular texture, cut up foods. The resident was noted to prefer small portions. Staff were to adapt effective behavioural strategies to get the resident to eat sufficient amounts with several re-approaches required. If they still refused to eat then offer

comfort foods as per menu, and give both choices if tolerated. During the lunch meal on May 13, 2014, the resident did not consume any of the lunch meal and was only approached to remove the soup from the table. The entree remained on the table until the end of the service with the meal not being consumed. The resident was not re-approached nor comfort foods offered as per the plan. During the lunch meal on May 14, 2014, the resident was not provided with small portions as per the plan of care. (156)
J. The plan of care for resident #72 indicated that they were to be provided with a modified diabetic diet and not receive regular juice. During the afternoon snack pass on May 14, 2014, the resident was provided regular orange juice. The FSM confirmed that orange juice served May 14, 2014, was not diabetic juice and should not have been served to the resident. (585) [s. 6. (7)]

3. The licensee did not ensure that the plan of care was revised when care set out in the plan had not been effective.

A. The plan of care for resident #11 indicated that a specific bell was to be provided within reach to alert the staff when assistance was required. Resident interview on May 15, 2014, revealed that the specific bell was no longer being used as it was not effective. The resident indicated that at present the staff were to clip the hard wired call bell to their chair within reach of their hand. Registered staff confirmed that the initial bell was ineffective and that the plan had not been revised to reflect this change. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 written plan of care for each resident set out the planned care for the resident and that the plan of care is revised when care set out in the plan is not effective, to be implemented voluntarily.

WN #2: 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,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

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. (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).
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The food production system did not at a minimum provide for standardized recipes and production sheets for all menus.

A. Recipes were not standardized to provide clear direction to guide staff in food production.
Soup recipes did not provide clear direction with regards to the addition of thickener. The recipes for puree chicken rice soup and puree cabbage soup indicated "add thickener if required", however, no quantities of thickener were indicated for each type of soup, nor did the recipe indicate to what consistency the soup would be thickened to (nectar, honey, pudding). (156)
B. On May 16, 2014, during the afternoon nourishment pass, a PSW verbalized that there was to be apple, peach, and cranberry juice on the cart. It was confirmed by the PSW that the juice pitchers did not contain any labels. The PSW poured a juice for resident #72, but then indicated it was not appropriate for the resident and that there was no diabetic juice available for snack service. The PSW continued to serve the resident. The FSM confirmed on May 15, 2014, that the peach juice, on the cart, was the diabetic option for the afternoon snack and the expectation for dietary staff to prepare diabetic juices in pitchers, clearly labeled for diabetic residents. (585)
C. Recipes were not always followed.
i. On May 14, 2014, the recipe for puree chicken rice soup indicated that crackers were to be included in the soup, however as confirmed by the cooks the pureed soup

did not contain crackers. (156)
ii. On May 14, 2014, during the afternoon nourishment pass, a PSW prepared a thickened drink using Resource Thicken-Up Clear for resident #71. The PSW stated the resident required thick fluids. The staff poured regular texture juice into a cup and stated the cup held 120 mL of fluid, before adding two scoops of thickener into the juice and mixed it. The PSW then added an additional half scoop and stated the drink was not thick enough. The instructions for the thickener directed to add two scoops for 125 mL of fluid. The drink appeared less than the required thickness when provided to the resident, less than 5 minutes after preparation. (585)
D. Food production numbers on the production sheets did not accurately reflect the quantities to prepare.
The production sheets for May 14, 2014, indicated that two portions of puree toast with jam were to be prepared for a specific floor. The floor had a total of four residents who required a puree textured diet, and the indicated production would not have provided sufficient portions if all residents choose this menu item. [s. 72. (2) (c)]

2. The food production system did not at a minimum provide for preparation of all menu items according to the planned menu.

A. The planned therapeutic menu was not always followed.
i. The therapeutic menu was not followed for a specific floor during the lunch meal on May 13, 2014. The menu indicated that jello was to be provided for those on a regular diet, however, the dietary aide reported that all jello was diet. The menu indicated that jello was to be provided for those on a puree textured diet, however, the dietary aide reported that those on a puree diet were not to receive jello and provided them lemon pudding. (156)
ii. The therapeutic menu was not followed on a specific floor during the breakfast meal on May 13, 2104. The menu indicated that oatmeal was to be provided, however cream of wheat was served, as confirmed by the dietary aide. (585)
B. The planned menu portion sizes indicated on the therapeutic menu were not always followed.
i. During the lunch meal on a specific floor on May 13, 2014, the therapeutic menu indicated that a #10 scoop was to be used for coleslaw, however, a #8 scoop was used. (156)
ii. During the lunch meal on two identified floors on May 15, 2014, the therapeutic menu indicated that a fruit tart was to be provided for those on a regular diet and a mini tart for those on a small, modified diet or energy controlled, diet however, all diets received the same size tart. The therapeutic menu indicated that the portion size for

minced tossed salad was a #10 scoop, however a #8 scoop was used on one floor for this item. (156)
C. Food production did not always allow for second helpings and the home ran out of menu items.
i. During the lunch meal on a specified floor on May 14, 2014, there was insufficient quantity of puree spinach salad and residents had to wait while the staff obtained more from the kitchen. There was no opportunity to request a different food item or second helpings, as all of the panned portions of minced spinach salad, puree spinach salad, and puree tossed salad were used up in the servery. (585)
ii. During the lunch meal on a specified floor on May 15, 2014, opportunity to make a different selection or request second helpings were not options as all of the panned portions of puree spinach, puree tossed salad and puree grilled cheese were served. (156)
D. The quantities on the recipes did not match the production sheets to guide food production.
i. The production sheet indicated that 80 regular portions were required of chicken rice soup and 47 portions of pureed soup. Dietary staff indicated that they prepare all the regular soup and then take the appropriate portions to puree from that quantity. Although the staff indicated that the recipe was followed, they reported that they prepared 93 portions as per the recipe, this indicated that there were only 13 portions available to puree and not the required 47. The staff member then indicated that they prepared 125 portions of the item which would indicate that the home was two portions short, for resident needs. (156)
ii. The recipe for pureed breakfast sausage was for 37 portions, however, the staff reported that 40 portions were prepared. (156)
E. The posted menu did not always reflect what was served.
i. On a specified floor on May 13, 2014, the posted breakfast menu indicated that oatmeal was to be served, however cream of wheat was served. (585)
ii. On May 14, 2014, the posted menu indicated that parslied parsnips would be served at the lunch meal, however, the recipe did not include parsley nor did the appearance of final product that was served to the residents. (156) [s. 72. (2) (d)]

3. Not 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. Foods did not always appear appetizing and food quality may not have been preserved.

i. During the lunch meal on a specified floor on May 13, 2014, the puree macaroni and beef appeared gluey and had small chunks of pasta in it. (156)
On another floor the inspector sampled the puree macaroni and beef and tasted small chunks of ground beef. The entree seemed pasty in appearance and taste. (585)
ii. During the lunch meal on a specific floor on May 15, 2014, the bananas were green and the minced salad was found to be of a watery consistency. (156)
On another floor on May 15, 2014, the pureed quiche appeared lumpy and of a gluey consistency. The pureed grilled cheese was noted to be gluey and there appeared to be a clump of external crust in the puree mix. (585)

2. Not all food and fluids in the food production system were prepared, stored and served using methods to prevent adulteration, contamination and food borne illness.
A. Temperatures were not always found to be palatable or in the safe temperature zone. The temperature range in which food-borne bacteria can grow, known as the danger zone is 4 to 60 °C (40 to 140 °F).
i. During the lunch meal on a specified floor on May 13, 2014, minced beef macaroni casserole was probed at 48 °C, minced green beans were probed at 56 °C and the tuna salad sandwich was probed at 8°C . (156)
On another floor, the regular texture beef macaroni casserole was probed at 51 °C, pureed texture beef macaroni casserole was probed at 55 °C, minced textured green beans were probed at 58 °C and regular texture green beans were probed at 59 °C. (585)
ii. During the lunch meal on a floor on May 14, 2014, sliced turkey was probed at 8 °C, minced turkey at 17 °C, puree turkey at 6 °C, minced egg was probed at 15 °C and puree egg was probed at 19 °C. (156)
During the lunch meal on another floor, the regular and minced parsnips and regular texture sausage were probed at 44 °C, minced sausage was 49°C and pureed turkey at 15 °C. (585)
iii. During the lunch meal on May 15, 2014, in a dining room, puree grilled cheese was probed at 46 °C, puree quiche was probed at 53 °C, regular spinach salad with dressing was probed at 6 °C and regular texture tart was probed at 8 °C. (585) [s. 72. (3)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system put in place, was complied with.

A. The home had a policy #RC-09-02-01, Resident Client Falls, last revised November 2013, which outlined that "for 48 hours following the fall staff are to obtain vital signs every eight hours, observe resident for injuries and change in mental status, and document in resident clients progress notes every shift".
i. The plan of care for resident #46 indicated they sustained an unwitnessed fall in 2014. The clinical record did not include post fall shift documentation on a specified day for day and night shifts, nor on a second day shift. Interview with registered staff confirmed that post fall documentation was not included in the progress notes as specified in the policy. (528)
ii. Resident #51 was found on the floor in 2014. The resident was initially assessed by staff post incident and neurological vital signs completed. The resident did not have documentation completed in the progress notes every shift for 48 hours post fall, this was confirmed during an interview with the registered staff. (168) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system put in place, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. Not all equipment, supplies, devices, assistive aids or positioning aids in the home were used in accordance with manufacturers' instructions.

Resident #52 was observed on May 8, and 14, 2014, to use a front fastening clip style seat belt while up in the chair. The belt was applied loosely around the abdomen allowing a full hand width between the resident and the belt. Interview with PSW staff on May 14, 2014, confirmed that the belt was not applied according to manufacturers' instructions, as communicated in the plan of care. The PSW adjusted the device to allow two finger between the belt and the resident's abdomen once the concern was identified. The RPN confirmed that the belt was used as a Personal Assistance Services Device (PASD) for the resident, to support positioning. [s. 23.]

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 equipment, supplies, devices, assistive aids or positioning aids in the home are used in accordance with manufacturers' instructions, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on an interdisciplinary assessment with respect to safety risks.

A. The plan of care for resident #21 indicated they required bed rails raised when in bed for safety. Review of clinical records did not include a formalized assessment of bed rail use and associated safety risks. Interview with the DOC confirmed that the home did not complete a formalized assessment related to bed rail use for the resident.
B. The plan of care for resident #14 indicated they required bed rails raised when in bed for safety. Review of clinical records did not include a formalized assessment of bed rail use and associated safety risks. Interview with the DOC confirmed that the home did not complete a formalized assessment related to bed rail use for the resident. [s. 26. (3) 19.]

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 plan of care is based on an interdisciplinary assessment with respect to safety risks, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. Not every restrained resident was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Review of the plan of care for resident #14 indicated they required a side fastening seat belt restraint when sitting in the wheelchair. On May 12, 2014, at approximately 1150 hours, the side fastening seat belt was noted to be loose and could be pulled from the resident's body to mid thigh. Interview with registered staff confirmed that the restraint was not applied as per manufacture instructions, which included that the seat belt fit approximately two fingers from the resident's body. The restraint was tightened by registered staff according to manufacture instructions. [s. 30. (1) 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 residents are only restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee did not ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

A. Subsection 33(4) of the Long Term Care Homes Act, identified that the use of a Personal Assistance Services Device (PASD) may by included in the plan of care only if it was consented to by a resident or a substitute decision maker (SDM) of the resident with authority to give consent.
i. Residents #14 and #21 were identified in their plans of care and observation to use bed rails raised when in bed and a tilt wheelchair for safety and positioning. A review of the clinical records did not include consents for the use of bed rails or the tilt wheelchairs. Interview with registered staff confirmed that consent was not obtained for the use of bed rails or tilt wheelchairs as PASD's. (528)
ii. The plan of care for resident #11 indicated the use of a front fastening seat belt. The PASD Assessment dated April 17, 2014, indicated that the resident utilized both a belt and a table top for positioning. Interview with registered staff confirmed that the table top was not included in the plan of care nor the PASD Flowsheets for the resident. (582) [s. 33. (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 a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. The plan of care for resident #22 indicated they had multiple areas of altered skin integrity. From May 2013, until April 2014, recurring open areas were being treated. Review of the clinical record did not include weekly skin assessments for the time periods of December 28, 2013, and January 7, 2014, and from March 19, 2014, until April 14, 2014. Interview with registered staff confirmed that weekly assessments were not completed by registered staff during the identified time periods. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents' or Family Council in the development and carrying out of the satisfaction survey.

A. Interview with the President of Residents' Council and the Director of Recreation and Leisure identified that the licensee did not seek the advice of the Council in the development of the satisfaction survey. This was also confirmed in a review of the Meeting Minutes for late 2013 and 2014. (168)
B. A review of the Family Council Meeting Minutes for the previous 12 months included no information that the annual satisfaction survey had been reviewed by the Council. Interviews with the Council President and the appointed assistant on May 13, 2014, confirmed that the satisfaction survey had not previously been reviewed by the Family Council for development and carrying out of the survey. (582) [s. 85. (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 the advice of the Residents' and Family Council is sought in the development and carrying out of the satisfaction survey, to be implemented voluntarily.

WN #10: 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).

Findings/Faits saillants :

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

The home had a Hand Hygiene Program, INF-05-03-01, last revised March 2013, which identified that staff should complete hand hygiene before and after contact with the resident and their environment.
A. During the lunch meal on May 14, 2014, in a home area, a PSW was observed to scrape uneaten food off of dirty dishes, and then continue to serve food without washing or sanitizing hands.
B. During the afternoon snack pass on May 14, 2014, in the same home area, a PSW was observed to remove a cookie out of a bulk bag on the snack cart with their bare hand and serve it to a resident. The PSW then removed a soiled glass from the resident's room without washing or sanitizing their hands before they continued to serve snacks and drinks to other residents. The PSW did not wash their hands for the remainder of the observed snack pass.
C. During the afternoon snack pass on May 15, 2014, in the home area, a PSW was observed to remove a cookie out of a bulk bag on the snack cart with their bare hand and serve it to a resident. The PSW then removed a soiled glass from the resident's room without washing or sanitizing their hands before they continued to serve snacks and drinks to other residents. The PSW was also noted to touch their face multiple times during the observed snack pass without completing hand hygiene following contamination. The PSW confirmed the expectation that hand hygiene be completed after touching soiled dishes, skin contact, and resident care. [s. 229. (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 that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The home, furnishings and equipment were not maintained in a safe condition and in a good state of repair.

The toilet in the shower room on the fourth floor was missing a tank lid during the course of the inspection. Interview with the MS confirmed that he was made aware of the issue two days prior and was in the process of locating a new lid as the home did not have standard toilets. It was anticipated that the lid would not be replaced for an extended length of time. [s. 15. (2) (c)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council Meeting Minutes identified that not all concerns or recommendations received were responded to in writing within 10 days.
i. Meeting Minutes for January 2014, included a concern related to a broken shower chair, which was not responded to by the licensee.
ii. Meeting Minutes for March 2014, included a concern related to pest control, which was not responded to by the licensee.
iii. Meeting Minutes for April 30, 3013, included a concern related to pest control, which was not responded to by the licensee.
Interview with the Director of Recreation and Leisure confirmed that most concerns or recommendations discussed at Council were addressed immediately by the invited management staff at the meeting, however confirmed that the minutes or other corresponding documentation was not reflective of this information or action(s) of the home. [s. 57. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee did not ensure that concerns or recommendations received by Family Council were responded to in writing within 10 days.

A review of the Family Council Meeting Minutes for the previous five months indicated that 13 concerns were identified during the meetings and that there was no documentation to reflect a written response had been provided regarding these concerns. Interviews with the Family Council President and the Family Council Assistant confirmed that written responses to concerns were not completed. [s. 60. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The home's menu cycle did not included alternate choices of entrees, vegetables, and desserts at lunch and dinner.

Resident #60 was on a specified diet and had an individualized menu as per the plan of care. During the lunch meal on May 13, 2014, only one choice of entrée was available for the resident The regular menu consisted of a choice of beef casserole or tuna salad sandwich. It was confirmed by the dietary aide, there was only one entree (macaroni and cheese) available for the specified diet, that there was not a separate menu developed and that the kitchen would just send up appropriate items for the resident. The following day, an individualized menu was found by the FSM, however, two choices were not always available on the menu. (156) [s. 71. (1) (c)]

WN #15: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Not all meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

During the observed lunch meal on a specified floor on May 13, 2014, residents #60 and #61 were provided with both their soup and the main entrée at the same time. The plans of care for the residents were reviewed and did not indicate that their needs included to receive soup and entree at the same time. The plan of care for resident #61 directed staff not to offer the show plates but rather ask "would you like a little bit" to avoid the resident feeling overwhelmed. [s. 73. (1) 8.]

WN #16: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Procedures were not developed and implemented for addressing incidents of lingering offensive odours.

A shower room was found to be malodourous. On May 8, 2014, at approximately 15:20 hours, on May 12, 2014, at approximately 11:30 hours, and on May 13, 2014, at approximately 14:00 hours, the shower room was found have a lingering urine odour. Interview with the MS confirmed he was made aware of the situation on May 15, 2014, and planned to use the mobile electronic deodorizer to assist with removing the odour. [s. 87. (2) (d)]

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

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

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 30. (2)	CO #002	2014_248214_0009	168
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2014_248214_0009	168

Issued on this 13th day of June, 2014

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

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) :	LISA VINK (168), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), JENNIFER ROBERTS (582), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2014_188168_0013
Log No. / Registre no:	H-000551-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 21, 2014
Licensee / Titulaire de permis :	THE THOMAS HEALTH CARE CORPORATION 490 Highway #8, STONEY CREEK, ON, L8G-1G6
LTC Home / Foyer de SLD :	ARBOUR CREEK LONG-TERM CARE CENTRE 2717 KING STREET EAST, HAMILTON, ON, L8G-1J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DORCAS HAIZEL

To THE THOMAS HEALTH CARE CORPORATION, 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) (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 #43, #44, #62, #63,#64, #65, #70, #71, #61 and #72, as specified in their plans.

Grounds / Motifs :

1. Previously identified: October 2011 - as a VPC, January 2013 - as a VPC, March 2013 - as a VPC, and February 2014 - as a VPC.

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 #43 indicated that they were to have small portions at mealtimes. During lunch on May 8, 2014, the resident was served a full portion. Interview with staff confirmed that the resident did not receive the serving specified in the plan of care. (528)
B. The plan of care for resident #44 indicated they were to receive a regular diet, regular texture, with meat cut up. During lunch on May 8, 2014, the resident was served a hamburger on a bun. Interview with staff confirmed that the hamburger patty was not cut up as specified in the plan of care. (528)
C. The plan of care for resident #62 indicated that they were to be provided with double portions at all meals as per request. During the lunch meal on May 13, 2014, the resident was provided with regular portions. (585)
D. The plan of care for resident #63 indicated that they were to be provided with a small diet (half portions) as per the therapeutic menu. The resident was identified on the plan to be a small eater. During the lunch meal on May 13, 2014, the resident was provided with regular portions. (585)
E. The plan of care for resident #64 indicated that they were to be provided with

a small diet (half portions) as per the therapeutic menu. During the lunch meal on May 13, 2014, the resident was provided with regular portions. (585)
F. The plan of care for resident #65 indicated that they were to be provided with a modified diabetic diet, minced texture and pureed meat. During the lunch meal on May 13, 2014, the resident was provided with regular soup. It was observed and verbalized by a PSW that the soup had large chunks of meat, carrots and noodles in it. (156)
G. The plan of care for resident #70 indicated that they were to be provided with a small diet (half portions), regular texture. During the lunch meal on May 14, 2014, the resident was provided with a regular portion of vegetables (parsnip). (585)
H. The plan of care for resident #71 indicated that they were to be provided with an energy controlled, puree diet. During the lunch meal on May 14, 2014, the resident was provided a regular sized portion of puree bread, which was a larger portion than the plan directed. (585)
I. The plan of care for resident #61 indicated to provide a small diet (half portions), regular texture, cut up foods. The resident was noted to prefer small portions. Staff were to adapt effective behavioural strategies to get the resident to eat sufficient amounts with several re-approaches required. If they still refused to eat then offer comfort foods as per menu, and give both choices if tolerated. During the lunch meal on May 13, 2014, the resident did not consume any of the lunch meal and was only approached to remove the soup from the table. The entree remained on the table until the end of the service with the meal not being consumed. The resident was not re-approached nor comfort foods offered as per the plan. During the lunch meal on May 14, 2014, the resident was not provided with small portions as per the plan of care. (156)
J. The plan of care for resident #72 indicated that they were to be provided with a modified diabetic diet and not receive regular juice. During the afternoon snack pass on May 14, 2014, the resident was provided regular orange juice. The FSM confirmed that orange juice served May 14, 2014, was not diabetic juice and should not have been served to the resident. (585) [s. 6. (7)] (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the food production system provides for standardized recipes and production sheets for all menus and preparation of all menu items according to the planned menu.
The plan shall include how the home will:
a. ensure that the recipes and production sheets are standardized
b. ensure that menu items are prepared according to the menu including following recipes and portion sizes
c. provide staff education related to the changes
d. conduct quality management activities that will be implemented to target the specific concerns identified.
The plan is to be submitted electronically to Carol.Polcz@ontario.ca by June 9, 2014.

Grounds / Motifs :

1. Previously identified as a CO October 2013.

The food production system did not at a minimum provide for standardized recipes and production sheets for all menus.

A. Recipes were not standardized to provide clear direction to guide staff in food production.
Soup recipes did not provide clear direction with regards to the addition of thickener. The recipes for puree chicken rice soup and puree cabbage soup indicated "add thickener if required", however, no quantities of thickener were indicated for each type of soup, nor did the recipe indicate to what consistency the soup would be thickened to (nectar, honey, pudding). (156)
B. On May 16, 2014, during the afternoon nourishment pass, a PSW verbalized that there was to be apple, peach, and cranberry juice on the cart. It was confirmed by the PSW that the juice pitchers did not contain any labels. The PSW poured a juice for resident #72, but then indicated it was not appropriate for the resident and that there was no diabetic juice available for snack service. The PSW continued to serve the resident. The FSM confirmed on May 15, 2014, that the peach juice, on the cart, was the diabetic option for the afternoon snack and the expectation for dietary staff to prepare diabetic juices in pitchers, clearly labeled for diabetic residents. (585)
C. Recipes were not always followed.
i. On May 14, 2014, the recipe for puree chicken rice soup indicated that crackers were to be included in the soup, however as confirmed by the cooks the pureed soup did not contain crackers. (156)
ii. On May 14, 2014, during the afternoon nourishment pass, a PSW prepared a thickened drink using Resource Thicken-Up Clear for resident #71. The PSW stated the resident required thick fluids. The staff poured regular texture juice into a cup and stated the cup held 120 mL of fluid, before adding two scoops of thickener into the juice and mixed it. The PSW then added an additional half scoop and stated the drink was not thick enough. The instructions for the thickener directed to add two scoops for 125 mL of fluid. The drink appeared less than the required thickness when provided to the resident, less than 5 minutes after preparation. (585)
D. Food production numbers on the production sheets did not accurately reflect the quantities to prepare.
The production sheets for May 14, 2014, indicated that two portions of puree toast with jam were to be prepared for a specific floor. The floor had a total of four residents who required a puree textured diet, and the indicated production would not have provided sufficient portions if all residents choose this menu item. [s. 72. (2) (c)]

2. The food production system did not at a minimum provide for preparation of

all menu items according to the planned menu.

A. The planned therapeutic menu was not always followed.
i. The therapeutic menu was not followed for a specific floor during the lunch meal on May 13, 2014. The menu indicated that jello was to be provided for those on a regular diet, however, the dietary aide reported that all jello was diet. The menu indicated that jello was to be provided for those on a puree textured diet, however, the dietary aide reported that those on a puree diet were not to receive jello and provided them lemon pudding. (156)
ii. The therapeutic menu was not followed on a specific floor during the breakfast meal on May 13, 2104. The menu indicated that oatmeal was to be provided, however cream of wheat was served, as confirmed by the dietary aide. (585)
B. The planned menu portion sizes indicated on the therapeutic menu were not always followed.
i. During the lunch meal on a specific floor on May 13, 2014, the therapeutic menu indicated that a #10 scoop was to be used for coleslaw, however, a #8 scoop was used. (156)
ii. During the lunch meal on two identified floors on May 15, 2014, the therapeutic menu indicated that a fruit tart was to be provided for those on a regular diet and a mini tart for those on a small, modified diet or energy controlled, diet however, all diets received the same size tart. The therapeutic menu indicated that the portion size for minced tossed salad was a #10 scoop, however a #8 scoop was used on one floor for this item. (156)
C. Food production did not always allow for second helpings and the home ran out of menu items.
i. During the lunch meal on a specified floor on May 14, 2014, there was insufficient quantity of puree spinach salad and residents had to wait while the staff obtained more from the kitchen. There was no opportunity to request a different food item or second helpings, as all of the panned portions of minced spinach salad, puree spinach salad, and puree tossed salad were used up in the servery. (585)
ii. During the lunch meal on a specified floor on May 15, 2014, opportunity to make a different selection or request second helpings were not options as all of the panned portions of puree spinach, puree tossed salad and puree grilled cheese were served. (156)
D. The quantities on the recipes did not match the production sheets to guide food production.
i. The production sheet indicated that 80 regular portions were required of chicken rice soup and 47 portions of pureed soup. Dietary staff indicated that

they prepare all the regular soup and then take the appropriate portions to puree from that quantity. Although the staff indicated that the recipe was followed, they reported that they prepared 93 portions as per the recipe, this indicated that there were only 13 portions available to puree and not the required 47. The staff member then indicated that they prepared 125 portions of the item which would indicate that the home was two portions short, for resident needs. (156)
ii. The recipe for pureed breakfast sausage was for 37 portions, however, the staff reported that 40 portions were prepared. (156)
E. The posted menu did not always reflect what was served.
i. On a specified floor on May 13, 2014, the posted breakfast menu indicated that oatmeal was to be served, however cream of wheat was served. (585)
ii. On May 14, 2014, the posted menu indicated that parslied parsnips would be served at the lunch meal, however, the recipe did not include parsley nor did the appearance of final product that was served to the residents. (156) [s. 72. (2) (d)]
(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant:
2013_122156_0025, CO #001;
2013_122156_0025, CO #002;
2013_188168_0015, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan 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 prevent adulteration, contamination and food borne illness.
The plan shall include how the home will:
a. ensure recipes are available and followed
b. prevent the risk of contamination and food borne illness
c. provide staff education related to changes
d. complete quality management activities that will be implemented to target the specific non compliance.
The plan shall be submitted to Carol.Polcz@ontario.ca by June 9, 2014.

Grounds / Motifs :

1. Previously identified as a CO in May 2013 and October 2013

1. Not 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. Foods did not always appear appetizing and food quality may not have been preserved.
i. During the lunch meal on a specified floor on May 13, 2014, the puree

macaroni and beef appeared gluey and had small chunks of pasta in it. (156)
On another floor the inspector sampled the puree macaroni and beef and tasted small chunks of ground beef. The entree seemed pasty in appearance and taste. (585)
ii. During the lunch meal on a specific floor on May 15, 2014, the bananas were green and the minced salad was found to be of a watery consistency. (156)
On another floor on May 15, 2014, the pureed quiche appeared lumpy and of a gluey consistency. The pureed grilled cheese was noted to be gluey and there appeared to be a clump of external crust in the puree mix. (585)

2. Not all food and fluids in the food production system were prepared, stored and served using methods to prevent adulteration, contamination and food borne illness.
A. Temperatures were not always found to be palatable or in the safe temperature zone. The temperature range in which food-borne bacteria can grow, known as the danger zone is 4 to 60 °C (40 to 140 °F).
i. During the lunch meal on a specified floor on May 13, 2014, minced beef macaroni casserole was probed at 48 °C, minced green beans were probed at 56 °C and the tuna salad sandwich was probed at 8°C . (156)
On another floor, the regular texture beef macaroni casserole was probed at 51 °C, pureed texture beef macaroni casserole was probed at 55 °C, minced textured green beans were probed at 58 °C and regular texture green beans were probed at 59 °C. (585)
ii. During the lunch meal on a floor on May 14, 2014, sliced turkey was probed at 8 °C, minced turkey at 17 °C, puree turkey at 6 °C, minced egg was probed at 15 °C and puree egg was probed at 19 °C. (156)
During the lunch meal on another floor, the regular and minced parsnips and regular texture sausage were probed at 44 °C, minced sausage was 49°C and pureed turkey at 15 °C. (585)
iii. During the lunch meal on May 15, 2014, in a dining room, puree grilled cheese was probed at 46 °C, puree quiche was probed at 53 °C, regular spinach salad with dressing was probed at 6 °C and regular texture tart was probed at 8 °C. (585) [s. 72. (3)] (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

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

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 21st day of May, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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