Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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, 11ième étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

This report has been revised to reflect a new compliance date and replaces the inspection report dated June 8, 2012. MW

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 29, 30, Apr 10, 11, 12, 13, 16, 27, May 1, 31, 2012	2012_066107_0007	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

MALTON VILLAGE LONG TERM CARE CENTRE
7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Registered Dietitian, Physician, Registered staff, front line nursing and dietary staff, and residents.

During the course of the inspection, the inspector(s) Observed food production systems and the dinner meal service, reviewed clinical health records for four identified residents, and reviewed relevant policies and procedures related to complaint H-000416-12.

The following Inspection Protocols were used during this inspection:

Food Quality

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 69.1,2] Previously issued as VPC September 29, 2010 and March 1, 2011.
The licensee did not ensure that an identified resident was assessed using an interdisciplinary approach after significant weight loss of 11% in one month, 7.6% x in one month, and 16.8 % in three months over a three month period, and action was not taken and outcomes were not evaluated for effectiveness. A referral to the Registered Dietitian was initiated by the Nurse Practitioner related to poor nutritional intake and the nutritional assessment was completed, however, an evaluation of the effectiveness of nutritional interventions in relation to the resident's nutritional intake, energy requirements, and care planning goals did not occur. The resident was routinely refusing meals, however, the ordered supplement was insufficient to cover the energy deficit and the resident had significant weight loss the following month. The Registered Dietitian did not assess the resident after the significant weight loss and action was not taken to address the weight loss. The resident's plan of care identified a goal for weight maintenance or weight gain, however, when the resident fell below their goal weight range, a nutritional assessment was not completed and the plan of care was not revised. At the nutritional assessment the next month, the plan of care was not revised despite the significant weight loss below the resident's target weight, poor intake, and poor hydration. The resident's nutritional intake was poor (52-78% of meals taken poorly or refused over a five month period). The resident had further significant weight loss, however, a nutritional assessment of the significant weight loss did not occur and the plan of care was not revised.
The resident was documented as having poor hydration over a 72 hour period numerous days over a two month period. A multidisciplinary assessment including the Registered Dietitian did not occur with action taken to address the poor hydration. The Home's Hydration Program policy identified that a referral would be made to the Registered Dietitian after 72 hours of poor hydration, however, the Registered Dietitian did not assess the resident related to hydration over this time period.
2. [O.Reg. 79/10, s. 69.1,2,3]
The licensee did not ensure that action was taken and outcomes were evaluated for an identified resident after a significant weight loss of 10.5% over one month, 3 months and 6 months. The resident had poor nutritional intake during this time and an assessment of the resident's intake in relation to energy requirements and interventions (nutritional supplements) did not occur at the nutritional assessment. Action was not taken to address the weight loss and the effectiveness of the plan of care was not evaluated. The physician wrote an order for the Registered Dietitian to see the resident related to weight loss, however the Registered Dietitian did not review the resident again until three months later.
3. [O.Reg. 79/10, s. 69, 1, 2, 4]
The licensee did not ensure that an identified resident had actions taken and outcomes evaluated after a 14.4% significant weight loss in one month and a 4.7% weight loss over one month (2 months later) and an 18.7% weight loss over three months. The resident had a plan of care with goals for weight maintenance and consumption of 75% of meals and snacks. The plan of care was not revised after the significant weight loss to include strategies to prevent further weight loss or to increase consumption of meals and snacks, nor were the goals revised to reflect a change in resident condition. The effectiveness of the interventions was not evaluated in relation to the goals identified on the resident's plan of care.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

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).

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).

Findings/Faits saillants :

1. [O.Reg. 72(2)(c)] Previously issued as VPC December 13, 2011
Standardized recipes were not in place for the home's current food production system.
a) The home's recipes were based on a conventional cooking system, however, the home was using a cook/chill and rethermalization system. Recipes did not reflect actual production methods and did not provide clear direction to staff preparing meals (one example: recipes for vegetables reflected cooking until tender with service after cooking, however, the home was cooking vegetables a day in advance, cooling, then reheating them (cauliflower, peas, green beans) or thawing, texture modifying and then heating (broccoli)). Not all cooks were using the same methods and direction was not provided to staff in the serveries who were doing the reheating, resulting in an inconsistent final product.
b) The production sheet for the dinner meal March 29, 2012 did not include preparation of pureed garlic bread, however, this item was identified on the therapeutic extension menu. The item was not prepared and available for service to residents at the dinner meal March 29, 2012.
2. [O. Reg. 79/10, s. 72(2)(d)]
Not all menu items were prepared according to the planned menu at the observed dinner meal March 29, 2012.
The planned menu stated pureed garlic bread and pureed sage bread dressing, however, these items were not prepared and available for service, resulting in reduced choice, quality and nutritive value for the pureed menu.
3. [O.Reg. 79/10, s. 72(3)(b)]
Not all foods were prepared and stored using methods that prevented contamination and food borne illness.
a) Not all foods in the walk-in refrigerators were dated and labeled, resulting in potential for food borne illness.
b) Turkeys were stored on a shelf above prepared foods and condiments, resulting in potential for contamination and food borne illness.
c) The blast chiller wasn't working and foods were placed into the refrigerator for cooling. Cooling times identified on recipes were not met within the specified time frames, resulting in potential for food borne illness.
4. [O.Reg. 79/10, s. 72(3)(a)]
Not all food and fluids were prepared, stored, and served using methods that preserved taste, nutritive value, appearance and food quality.
a) Foods were prepared a day in advance using methods that did not preserve taste, nutritive value, or food quality.
i) Products that stated, "cook from frozen state for best quality" (e.g. chicken fingers, fish fillets, frozen vegetables) were thawed, cooked, cooled, and then reheated or thawed and then cooked. Reheating the products also reduces the nutritive value of the product. Recipes reflected a conventional cooking system versus cook/chill/retherm production method. Menu items could not be prepared according to the recipes, resulting in variation in flavour, texture and quality. (e.g. some vegetables were cooked day in advance, cooled, then reheated (cauliflower, peas, green beans), and some were thawed, texture modified and then heated in the servery (broccoli). Not all cooks were using the same methods and direction was not provided to staff in the serveries related to whether items were pre-cooked versus raw).
ii) Coleslaw was prepared a day in advance with mayonnaise and then served the next day, resulting in reduced quality.
b) Some meals for residents requiring a pureed texture were pre-portioned onto plates and left sitting on-top of the steam table pans, resulting in food temperatures that were less than those of food being hot held in the original containers.
c) Texture modified meals were not served with the same quality as the regular texture at the dinner meal March 29, 2011. Residents receiving the regular texture pork were served with a pork gravy, however, those receiving a texture modified meal were served pork with a brown gravy, which was not consistent with the menu or recipe.

Additional Required Actions:

CO # - 002 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 with ensuring that all menu items are prepared according to the planned menu, foods are prepared and stored using methods that prevent contamination and food borne illness, and all food and fluids are prepared, stored, and served using methods that preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #3: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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;
(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. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(c)]
The licensee did not ensure that the plan of care for an identified resident was reviewed and revised when the care set out in the plan was not effective.
At a nutritional assessment, the Registered Dietitian did not revise the plan of care despite significant weight loss (10.5% in one month), and a staged open area on the skin that was not healing. The wound was later being actively treated by the wound nurse and the resident had a care planning goal for improved skin integrity. The effectiveness of a physician order for 1 scoop of protein powder daily for wound healing, was not evaluated. Documentation did not reflect that this order was implemented (was not reflected on the Medication Administration Record) and staff could not confirm that the resident was routinely receiving the supplement.
2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(11)(b)]
a)An identified resident had a plan of care for weight maintenance within a specific weight range. The resident fell below this weight and had significant weight loss in one month (14.4%) and over three months(18.7%). The plan of care was not effective for the prevention of weight loss or for weight maintenance, however, different approaches had not been considered in the revision of the plan of care. Supplements were discontinued due to resident refusal, however, alternative strategies to prevent weight loss were not implemented. This was confirmed by the Registered Dietitian.
b)The Registered Dietitian did not consider different approaches in the revision of the plan of care for an identified resident. The resident fell below their target weight (identified on the resident's plan of care), however, interventions on the plan of care were not revised at the nutritional assessment. The Registered Dietitian confirmed alternative strategies were not considered in the revision of the plan of care.
c) At an identified nutritional assessment, the Registered Dietitian did not consider different approaches in the revision of the plan of care for an identified resident when the plan was ineffective. Nutritional interventions were not revised despite significant weight loss (10.5% in one month) and a staged open area on the skin that was not healing. The resident had a plan of care with a goal for improved skin integrity. The Registered Dietitian confirmed alternative strategies had not been considered.
3. [LTCHA, 2007, S.O. 2007,c.8, s. 6(1)(c)]
The plan of care for an identified resident did not provide clear directions for the staff and others who provided direct care to the resident. The resident's plan related to constipation did not provide clear direction to staff providing care. The plan stated to eliminate foods causing adverse effects re: constipation, however, staff interviewed were unable to identify which foods would cause adverse effects for this resident. The plan also stated to increase fluid intake and provide high fibre foods, however, staff interviewed were unable to identify how to increase the fluid intake and identify foods that were high in fibre.
4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(b)]
Staff involved in the different aspects of care did not collaborate with each other in the development and implementation of an identified resident's plan of care so that different aspects of the care were integrated, consistent with and complemented each other.
Target fluid goals were inconsistent between different sections of the resident's plan of care (nursing sections and dietary sections).
5. [LTCHA, 2007, S.O. 2007, c.8, s.6(7)]
The care set out in the plan of care for an identified resident was not provided to the resident as specified in their plan. The resident had a physician order for 1 scoop of protein powder daily to assist with wound healing. This intervention did not get transcribed to the Medication Administration Record and was not being recorded as given. The intervention was identified on the resident's plan of care, however, it could not be confirmed that the resident was routinely receiving the supplement.

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 sections 6(1)(c), 6(4)(b), 6(7), 6 (10)(c), and 6(11)(b), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(4)]
The licensee did not ensure that the planned menu items were offered and available at the dinner meal March 29, 2012.
a) The planned menu identified pureed sage bread dressing and pureed garlic toast. These items were not prepared and were not available for residents requiring a pureed texture dinner meal. Residents requiring a pureed meal were not offered bread/grains with their meal, resulting in reduced nutritive value and quality/choice. Staff interviewed stated they do not routinely offer pureed grains to residents at the dinner meal.
b) Not all menu items were served according to the planned portion size. A #12 scoop was used for the sage bread stuffing when the menu identified a #8 scoop (smaller portion was served to residents due to insufficient quantity of stuffing prepared). A larger portion of pureed green beans and pureed turnip was served to residents than was identified on the planned menu (#8 versus #10). A 3 oz portion was used for the brown gravy versus a 1 oz portion as identified on the planned menu.
A 1oz portion was used for the minced crab filling (#20 scoop) versus a 2-3oz serving as identified on the menu for the lunch meal March 30, 2012.
c) Residents requiring a regular texture meal were not offered breadsticks with the lamb meal in one dining room, however, residents in the dining room on the other side were.

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 planned menu items are offered and available at each meal and snack, 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 subsections:

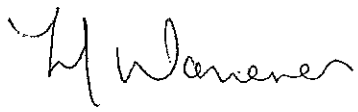
s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 26(4)(b)]
The Registered Dietitian did not assess an identified resident's nutritional status, including risks related to nutritional care at an identified nutritional review. At the nutritional review by the Registered Dietitian, the resident's diet texture order was upgraded. The resident was documented as having significant swallowing problems and was being seen by a Speech Language Pathologist (SLP) who recommended a lower diet texture order. The Registered Dietitian did not assess the need for the diet texture change and documentation does not reflect rationale for the diet texture change. Interview with the Registered Dietitian indicated the diet order change was in error, however, the diet order was in place for two months without correction. The diet order was not revised after an SLP recommendation for a downgraded texture.

Issued on this 8th day of June, 2012

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

This report has been revised to reflect a new compliance date and replaces the inspection report dated May 31, 2012.

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2012_066107_0007
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Mar 29, 30, Apr 10, 11, 12, 13, 16, 27, May 1, 31, 2012
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF PEEL 10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	MALTON VILLAGE LONG TERM CARE CENTRE 7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~WENDY BEATTIE~~ Ranjit Calay MO

To THE REGIONAL MUNICIPALITY OF PEEL, 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 :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

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

Order / Ordre :

The licensee shall ensure that all residents experiencing a significant or unplanned weight change, have the weight change assessed in relation to their goals identified on the plan of care, with actions taken and outcomes evaluated.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 69, 1, 2, 4]
The licensee did not ensure that an identified resident had actions taken and outcomes evaluated after a 14.4% significant weight loss in one month and a 4.7% weight loss over one month (2 months later) and an 18.7% weight loss over three months. The resident had a plan of care with goals for weight maintenance and consumption of 75% of meals and snacks. The plan of care was not revised after the significant weight loss to include strategies to prevent further weight loss or to increase consumption of meals and snacks, nor were the goals revised to reflect a change in resident condition. The effectiveness of the interventions was not evaluated in relation to the goals identified on the resident's plan of care. (107)
2. [O.Reg. 79/10, s. 69.1,2,3]
The licensee did not ensure that action was taken and outcomes were evaluated for an identified resident after a significant weight loss of 10.5% over one month, 3 months and 6 months. The resident had poor nutritional intake during this time and an assessment of the resident's intake in relation to energy requirements and interventions (nutritional supplements) did not occur at the nutritional assessment. Action was not taken to address the weight loss and the effectiveness of the plan of care was not evaluated. The physician wrote an order for the Registered Dietitian to see the resident related to weight loss, however the Registered Dietitian did not review the resident again until three months later. (107)
3. [O.Reg. 79/10, s. 69.1,2]
The licensee did not ensure that an identified resident was assessed using an interdisciplinary approach after significant weight loss of 11% in one month, 7.6% x in one month, and 16.8 % in three months over a three month period, and action was not taken and outcomes were not evaluated for effectiveness. A referral to the Registered Dietitian was initiated by the Nurse Practitioner related to poor nutritional intake and the nutritional assessment was completed, however, an evaluation of the effectiveness of nutritional interventions in relation to the resident's nutritional intake, energy requirements, and care planning goals did not occur. The resident was routinely refusing meals, however, the ordered supplement was insufficient to cover the energy deficit and the resident had significant weight loss the following month. The Registered Dietitian did not assess the resident after the significant weight loss and action was not taken to address the weight loss. The resident's plan of care identified a goal for weight maintenance or weight gain, however, when the resident fell below their goal weight range, a nutritional assessment was not completed and the plan of care was not revised. At the nutritional assessment the next month, the plan of care was not revised despite the significant weight loss below the resident's target weight, poor intake, and poor hydration. The resident's nutritional intake was poor (52-78% of meals taken poorly or refused over a five month period). The resident had further significant weight loss, however, a nutritional assessment of the significant weight loss did not occur and the plan of care was not revised.
The resident was documented as having poor hydration over a 72 hour period numerous days over a two month period. A multidisciplinary assessment including the Registered Dietitian did not occur with action taken to address the poor hydration. The Home's Hydration Program policy identified that a referral would be made to the Registered Dietitian after 72 hours of poor hydration, however, the Registered Dietitian did not assess the resident related to hydration over this time period. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

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 that ensures:
a) standardized recipes are in place for the home's current method of food production
b) production sheets include all required items
c) all menu items are purchased, prepared, and served according to the planned menu
The plan is to be submitted by June 15, 2012, to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, Fax 905-546-8255, e-mail: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 72(2)(c)]
Standardized recipes were not in place for the home's current food production system.
a) The home's recipes were based on a conventional cooking system, however, the home was using a cook/chill and rethermalization system. Recipes did not reflect actual production methods and did not provide clear direction to staff preparing meals (one example: recipes for vegetables reflected cooking until tender with service after cooking, however, the home was cooking vegetables a day in advance, cooling, then reheating them (cauliflower, peas, green beans) or thawing, texture modifying and then heating (broccoli)). Not all cooks were using the same methods and direction was not provided to staff in the serveries who were doing the reheating, resulting in an inconsistent final product.
b) The production sheet for the dinner meal March 29, 2012 did not include preparation of pureed garlic bread, however, this item was identified on the therapeutic extension menu. The item was not prepared and available for service to residents at the dinner meal March 29, 2012. (107)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : ~~Sep 30, 2012~~ Oct 31, 2012 MW

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

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 Clerk
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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

Director
c/o Appeals Clerk
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.

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

Ministère 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

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 :

Director
c/o Appeals Clerk
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

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

Director
c/o Appeals Clerk
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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 31st day of May, 2012

Signature of Inspector / Signature de l'inspecteur : M Warrener

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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