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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 8, 2019	2019_788721_0004	024410-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Seaforth Long Term Care Home
100 James Street SEAFORTH ON N0K 1W0

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

MEAGAN MCGREGOR (721), CASSANDRA ALEKSIC (689)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 21 and 22, 2019.

The following Critical Incident System (CIS) report was inspected during the course of this inspection:

CI #1135-000015-18/Log #024410-18 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Assistant Director of Care, the Food Service Manager, a Registered Nurse, a Dietary Aide, Personal Support Workers and residents.

The Inspectors also observed residents and the care provided to them, and reviewed clinical records and plans of care for identified residents.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident resulting in the death of resident #001. It was stated in the CIS report that resident #001 was eating food of a specific texture when staff noticed a change in the resident's condition.

The care plan in Point Click Care (PCC) for resident #001 at the time of the incident identified risks related to eating and stated that their food should be modified to a specific texture.

A review of the clinical record for resident #001 included the following documentation from the time of the incident: resident #001 was eating food of a specific texture when staff noticed a change in the resident's condition. Staff attempted to remove the food from resident #001's mouth and resuscitate the resident. Resident #001 was transferred to hospital via ambulance and was pronounced dead upon arrival to hospital.

During an interview with a specific staff member they stated that when they were working on the date of the incident, they put food that was not modified to the specific texture that resident #001 required in front of resident #001 and watched resident #001 eat the food that was not modified to the specific texture they required. This specific staff member told Inspector #721 that when a resident required their food to be modified to this specific texture it was the responsibility of the Personal Support Workers (PSWs) to ensure the food provided to the resident was modified to this specific texture.

During an interview Registered Nurse (RN) #103 stated that if there were any dietary interventions in place for a resident that this would be stated in both their care plan in PCC and in their Kardex and that all staff could access this information. RN #103 told Inspector #721 that resident #001 required their food to be modified to a specific texture. RN #103 also stated that it was the responsibility of the PSW staff to modify resident #001's food to this specific texture.

During an interview Food Service Manager (FSM) #104 stated that resident #001 was on a specific diet and texture type. The FSM stated that there were identified risks with resident #001 related to eating and that they sat at a table with PSW supervision. FSM #104 reviewed resident #001's care plan in PCC and stated that they had interventions which included modifying their food to a specific texture and verbal support from staff related to eating. The FSM stated that it was the PSW's responsibility to modify a resident's food to this specific texture. When asked how staff would know to modify a

resident's food to this specific texture, the FSM stated that the interventions would be on the sheet in the servery as well as in the residents' care plan.

During an interview PSW #102 stated that resident #001 was able to feed themselves, but was provided verbal support with eating. The PSW stated that the resident had identified risks related to eating. When asked where they or a new staff member would look to find information about the residents' plan of care related to dietary interventions, the PSW stated that they were not sure exactly where to find this, and that they just generally knew information about the residents or would ask the nurse on duty. When asked what level of eating assistance resident #001 required, the PSW stated that staff would monitor them while eating. The PSW stated that on the day of the incident, resident #001 was served food that was not modified to the specific texture that they required. PSW #102 stated that they saw resident #001 eat the food that was not modified to the specific texture they required. PSW #102 asked resident #001 to spit the food out and resident #001 looked at them and swallowed. The PSW stated that after this staff noticed a change in the resident's condition. The PSW stated that staff had served the plate of food to the resident and that if resident's required their food to be modified to the specific texture that was required by resident #001 then the PSWs would do this. Inspector #689 asked if the resident would be able to modify their food to this specific texture themselves, the PSW stated that they were not able to, and that this would have to be done for them. The PSW stated that they did not modify resident #001's food to the specific texture that was required by resident #001 on the date of the incident.

The licensee has failed to ensure that the care set out in the plan of care, related to modifying food to specific texture for resident #001, was provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 8th day of March, 2019

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MEAGAN MCGREGOR (721), CASSANDRA ALEKSIC (689)
Inspection No. / No de l'inspection :	2019_788721_0004
Log No. / No de registre :	024410-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 8, 2019
Licensee / Titulaire de permis :	CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Seaforth Long Term Care Home 100 James Street, SEAFORTH, ON, N0K-1W0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Stewart

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

To CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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 must be compliant with O.Reg. 79/10, s. 6(7).

Specifically, the licensee must:
a) Ensure that the care set out in the plan of care related to nutrition and food texture requirements is provided to any resident as specified in their plan of care.
b) Ensure that procedures are developed and implemented in the home to ensure that when any residents care plan states their specific nutrition and food texture requirements that staff have clear direction on what these requirements are.
c) Ensure that all Dietary Staff, Personal Support Workers, Registered Staff and any other staff that provide assistance with feeding residents are provided training on food texture modification, and the roles and responsibilities of staff related to dining and feeding. A documented record of this training must be maintained.

Grounds / Motifs :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident resulting in the death of resident #001. It was stated in the CIS report that resident #001 was eating food of a specific texture when staff noticed a change in the resident's condition.

The care plan in Point Click Care (PCC) for resident #001 at the time of the incident identified risks related to eating and stated that their food should be

modified to a specific texture.

A review of the clinical record for resident #001 included the following documentation from the time of the incident: resident #001 was eating food of a specific texture when staff noticed a change in the resident's condition. Staff attempted to remove the food from resident #001's mouth and resuscitate the resident. Resident #001 was transferred to hospital via ambulance and was pronounced dead upon arrival to hospital.

During an interview with a specific staff member they stated that when they were working on the date of the incident, they put food that was not modified to the specific texture that resident #001 required in front of resident #001 and watched resident #001 eat the food that was not modified to the specific texture they required. This specific staff member told Inspector #721 that when a resident required their food to be modified to this specific texture it was the responsibility of the Personal Support Workers (PSWs) to ensure the food provided to the resident was modified to this specific texture.

During an interview Registered Nurse (RN) #103 stated that if there were any dietary interventions in place for a resident that this would be stated in both their care plan in PCC and in their Kardex and that all staff could access this information. RN #103 told Inspector #721 that resident #001 required their food to be modified to a specific texture. RN #103 also stated that it was the responsibility of the PSW staff to modify resident #001's food to this specific texture.

During an interview Food Service Manager (FSM) #104 stated that resident #001 was on a specific diet and texture type. The FSM stated that there were identified risks with resident #001 related to eating and that they sat at a table with PSW supervision. FSM #104 reviewed resident #001's care plan in PCC and stated that they had interventions which included modifying their food to a specific texture and verbal support from staff related to eating. The FSM stated that it was the PSW's responsibility to modify a resident's food to this specific texture. When asked how staff would know to modify a resident's food to this specific texture, the FSM stated that the interventions would be on the sheet in the servery as well as in the residents' care plan.

During an interview PSW #102 stated that resident #001 was able to feed themselves, but was provided verbal support with eating. The PSW stated that the resident had identified risks related to eating. When asked where they or a new staff member would look to find information about the residents' plan of care related to dietary interventions, the PSW stated that they were not sure exactly where to find this, and that they just generally knew information about the residents or would ask the nurse on duty. When asked what level of eating assistance resident #001 required, the PSW stated that staff would monitor them while eating. The PSW stated that on the day of the incident, resident #001 was served food that was not modified to the specific texture that they required. PSW #102 stated that they saw resident #001 eat the food that was not modified to the specific texture they required. PSW #102 asked resident #001 to spit the food out and resident #001 looked at them and swallowed. The PSW stated that after this staff noticed a change in the resident's condition. The PSW stated that staff had served the plate of food to the resident and that if resident's required their food to be modified to the specific texture that was required by resident #001 then the PSWs would do this. Inspector #689 asked if the resident would be able to modify their food to this specific texture themselves, the PSW stated that they were not able to, and that this would have to be done for them. The PSW stated that they did not modify resident #001's food to the specific texture that was required by resident #001 on the date of the incident.

The licensee has failed to ensure that the care set out in the plan of care, related to modifying food to specific texture for resident #001, was provided to the resident as specified in the plan. [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 compliance history as they had 1 or more related
NC in last 36 months that included:
- written notification (WN) issued December 8, 2016 (2016_326569_0027); and
- voluntary plan of correction (VPC) issued December 8, 2016 (2016_326569_0027). (721)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 04, 2019

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, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Meagan McGregor

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