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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 7, 2015	2015_323130_0002	H-001833-15	Resident Quality Inspection

Licensee/Titulaire de permis

BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST SUITE 901 TORONTO ON M3J 2V5

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

BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

GILLIAN TRACEY (130), CATHY FEDIASH (214), KELLY HAYES (583)

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): January 28, 29, 30, February 3, 4, 5, 6, 10, 11, 12 and 13, 2015

Please Note: The following inspections were conducted simultaneously with this RQI: Follow-up H-001332-14 related to s. 6 (7), H-001333-14 related to r. 72 (2) and H-000743-13 related to r.33 (1).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Documentation Nurse, Registered staff, personal care providers (PCPs), Recreational Support Services Manager (RSSM), Social Services Coordinator (SSC), Nutrition Manager, Registered Dietitian (RD), dietary staff, President of Residents' Council, President of Family Council, residents and families.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Medication
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

12 WN(s)
7 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 33. (1)	CO #002	2013_202165_0011	583
O.Reg 79/10 s. 51. (2)	CO #001	2013_214146_0030	130
LTCHA, 2007 S.O. 2007, c.8 s. 75.	CO #001	2013_214146_0029	130

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 2007, c. 8, s. 6 (4).
(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; 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 licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) A review of an identified resident's clinical record indicated that they exhibited impaired skin integrity to a specified area, that had been present from 2014. A review of

the physician's orders indicated that on a specified date in 2015, the Nurse Practitioner (NP)wrote orders for pain assessments to be completed q.(every) shift and prn (when needed) if there was increased pain with movement of the affected area. A review of the resident's written plan of care dated 2015, indicated that pain assessments were only to be completed every shift. A review of the resident's Electronic Medication Administration Record (E-MAR) from a specified time in 2015, also indicated that pain assessments were only to be completed every shift. An interview with the DOC confirmed that the written plan of care for the resident had not provided clear directions to staff and others who provided direct care to the resident. (Inspector #214)

B) A review of resident #014's clinical record indicated that they exhibited impaired skin integrity to a specified area, which had been present since 2014. A review of the physician's orders indicated that on an identified date in 2015, the Nurse Practitioner (NP) wrote non-medicated treatment orders for the affected area. The treatment orders indicated that the treatment was to be completed every four days and prn if soiled. A review of the resident's E-MAR during a specified time period time in 2015, indicated that the treatment orders were to be completed twice weekly and prn if soiled. An interview with the DOC confirmed that that the written plan of care for the resident had not provided clear directions to staff and others who provided direct care to the resident. (Inspector #214) [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) A review of an identified resident's E-MAR indicated that on an identified date in 2014, the resident had impaired skin integrity to two identified areas whcih required a non medicated treatment ever three days and prn. A review of the resident's clinical record indicated that a skin assessment had not been completed until nine days after the implementation of the treatment. An interview with registered staff confirmed that the treatment in place was not based on an assessment of the resident's needs. (Inspector #214) [s. 6. (2)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) A review of an identified resident's Weekly Wound Assessment (Bates-Jensen) in

2014, indicated that the resident had impaired skin integrity to an identified area. A review of a wound assessment progress note written in 2014, also indicated that the resident continued to have ongoing immobility concerns causing a recurring worsening of the affected area. A review of the resident's Minimum Data Set (MDS) coding and Resident Assessment Protocol (RAP) completed on an identified date in 2014, indicated that the resident had no skin impairment; had a history of impaired skin integrity in the past 90 days and that their impaired skin integrity to the identified area had healed. A review of the resident's progress notes indicated that on an identified date in 2014, the resident's impaired skin integrity to the affected area had healed. An interview with the Documentation Nurse confirmed that the impaired skin integrity to the affected area had healed in 2014, and that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other. (Inspector #214)

B) On an identified date in 2014, the Quarterly MDS Assessment completed for an identified resident indicated they had moderate pain less than daily; however, the pain assessment completed the same day, using the Point Click Care (PCC) Pain Assessment, indicated the resident had moderate pain daily. On another identified date in 2014, the Annual MDS Assessment completed indicated they had moderate pain less than daily; however, the pain assessment completed on another date in 2014, using the PCC Pain assessment, indicated the resident had moderate pain daily. Registered staff interviewed confirmed the assessments were not were integrated, consistent with and did not complement each other. (Inspector #130) [s. 6. (4) (a)]

4. The licensee failed to ensure that the plan set out in the plan of care was provided to the residents as specified in the plan.

A) A review of an identified resident's written plan of care dated in 2015, indicated under activities that the resident was dependent on staff for activities and that staff would attempt to provide one to one activities two times per month. An interview with the RSSM indicated that attendance to activities was documented in the resident's progress notes under "Recreation Note". A review of these progress notes from a specified time period in 2014 until a time period in 2015 indicated that the resident received only one visit of a one to one activity in a specific month 2014. An interview with the RSSM indicated that one to one activities were provided during the Friendly Visits program and that weekly, the Comfort Care Coordinator would also provide one to one activities. A review of the one to one visits conducted by the Comfort Care Coordinator indicated that the resident had not received any one to one visit's nor was there any documentation of

attempt's made to provide one to one visits to the resident. A review of the home's activity calendars from the identified time period in 2014 and 2015 indicated that the Friendly Visits programs were offered during these months on three out of the six resident home areas; however, they were not offered on the home area that the resident resided on. An interview with the RSSM confirmed that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

B) During an interview in 2015 an identified resident shared they were not bathed twice weekly by the method of their choice. A review of their plan of care indicated they were to receive two showers per week per their preference. The bathing records were reviewed for a one month period in 2015 and it was documented on resident on their scheduled shower days three identified dates that the resident received a bed bath and on a fourth and fifth date during the identified month staff documented "not applicable". In an interview with the resident they confirmed that on three of the identified dates they received received a bed bath and it was their preference to have a shower and on two other dates during the identified time period they were not bathed. A review of the plan of care indicated the resident was able to make decisions about choice and preferences and had a cognitive performance scale assessed at two. In an interview with the Personal Support Worker (PSW)it was confirmed the resident would be able to provide an accurate recall of bathing provided. In an interview with the DOC on an identified date in 2015 it was confirmed that the resident was not showered at minimum twice per week per their preference. (Inspector #583)

C) A review of an identified resident's written plan of care dated in 2014, indicated that the resident was at high nutritional risk and that staff were to notify the Registered Dietitian (RD) if the resident consumed less than a specified volume of fluid for three consecutive days. A review of the "fluid intake" task in the Point of Care (POC) documentation system that was completed over a specified period in 2015, indicated that consecutively over a number identified time periods, the resident had consumed less than the specified volume of fluid daily. A review of the resident's clinical record indicated that the RD had not reassessed the resident when they consumed less than the specified volume of fluid for three consecutive days. An interview with registered staff confirmed that no dietary referrals had been completed for the dates identified and that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

D) A review of an identified resident's written plan of care dated in 2014, indicated that the resident was at high nutritional risk and that staff were to notify the RD if the resident

consumed less than 50 percent of their meal for three consecutive days. A review of the "amount eaten" task in the POC documentation system that was completed over a specified time period in 2015, indicated that on at least six occasions the resident consumed less than 50 percent of their meals. A review of the resident's clinical record indicated that the RD had not reassessed the resident when they consumed less than 50 percent of their meal for three consecutive days. An interview with registered staff confirmed that no dietary referrals had been completed for the dates identified and that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

E) A review of another identified resident's written plan of care dated 2015, indicated that the resident was at high nutritional risk and that staff were to notify the RD if the resident consumed less than a specified volume of fluid for three consecutive days. A review of the "fluid intake" task in the POC documentation system that was completed from over a period of time in 2015, indicated that consecutively over a period of time in 2015, the resident consumed less than the specified volume of fluid daily. An interview with the DOC confirmed that staff did not notify the RD when the resident consumed less than the specified volume for three consecutive days and that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

F) A review of another identified resident's written plan of care in 2015, indicated that the resident was at high nutritional risk and that staff were to notify the RD if the resident consumed less than 50 percent of their meal for three consecutive days. A review of the "amount eaten" task in the POC documentation system that was completed over a specified time period in 2015, indicated that consecutively over a specified time period in 2015 and consecutively over another time period in 2015, the resident consumed less than 50 percent of their meals. An interview with the DOC confirmed that staff did not notify the RD when the resident consumed less than 50 percent of their meal for three consecutive days and that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

G) A review of an identified resident's clinical record indicated they had impaired skin integrity to an identified area in 2014 to a specified date in 2015, for which the NP prescribed non-medicated treatment orders. On an identified date in 2015, the physician ordered a narcotic analgesic, to be administered prior to treatments. A review of the resident's E-MAR over a one month time period in 2015, indicated that on two identified dates, the resident received dressing changes to the affected area; however, no administration of the narcotic analgesic was documented as having been given. A review

of the Narcotic and Controlled Substance Administration Record on the identified dates, indicated that pain medication was not recorded as being administered. An interview with registered staff indicated that the medication had not been administered on the identified dates as the affected area had only been checked and not changed. The registered staff confirmed that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector# 214)

H) On a specific date in 2015, an identified resident was found in their washroom unattended sitting on the toilet in a sling which was attached to the sit to stand lift. Inspector #583 requested immediate assistance from a Registered Practical Nurse (RPN). A review of the plan of care of the identified resident indicated they required extensive assistance from two staff for transfers using the sit to stand lift and extensive assistance from two staff members for toileting due to their diagnosis. The RPN verified the resident was left unattended on the toilet, attached to the sit to stand lift and that toileting and transferring plan identified in the plan of care was not provided as specified in the plan. (Inspector #583)

I) A review of the plan of care for an identified resident indicated they were at moderate nutrition risk, on a regular minced textured diet and were to receive a supplement with meals. During a lunch observation on February 6, 2015 in an identified dining room it was noted that the resident's table setting was set with cutlery and poured beverages. Lunch service began at 1200 hours. In an interview with the dietary aide and RPN at 1245 hours it was confirmed that lunch service had finished, all residents meals had been plated and medication pass nutrition supplements had been provided. At 1250 hours the identified resident was observed by Inspector #583 and the DOC, to be sitting on their unit. In an interview with the Nutrition Manager, who was present during the dining observation in the specified dining room and the DOC, it was confirmed the resident was not offered a regular, minced texture meal or their ordered supplement at lunch as specified in the plan of care. (Inspector #583)

J) A review of the plan of care for an identified resident indicated the resident was to be provided a specific beverage at lunch. During a lunch observation on February 6, 2015 the resident was not offered the specific beverage. In an interview with the PCP and the dietary aide on February 6, 2015 it was confirmed that the resident was not provided the specific beverage as specified in their plan. (Inspector #583) [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's

care needs changed or care set out in the plan was no longer necessary.

A) A review of an identified resident's written plan of care dated 2015, indicated that environmental services staff were to place a room bacteria deodorizer in the room. An observation of the resident's room on February 5, 2015, indicated that no room bacteria deodorizer was present. An interview with PCP's and registered staff confirmed that the room bacteria deodorizer was present but had been removed approximately two weeks ago as it was no longer required. An interview with the DOC confirmed that the resident's plan of care was not reviewed and revised when care set out in the plan was no longer necessary. (Inspector #214)

B) The written plan of care for an identified resident indicated they ate in the main dining room; received active and passive range of motion two times per week; required at least two safety devices when in their chair at all times for safety; required "as much motivation as needed" and encouragement and coaxing to attend social and special event programs. Staff interviewed confirmed the resident's condition had changed, they were not receiving any invasive procedures, not participating in activities, no longer getting out of bed, no longer required safety measures in place and only receiving medication by injection. Not all aspects of the plan of care were updated to reflect the change in the resident's condition. (Inspector #130) [s. 6. (10) (b)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that there were standardized recipes and production sheets for all menus.

A) A record review of the week two menu production sheets from February 2 to February 8, 2015, showed the production sheets had not been completed. In an interview with the cook and the Nutrition Manager on February 10, 2015, it was confirmed that there were no completed production sheets for breakfast, lunch and dinner from February 2 to February 8, 2015. (Inspector #583)

B) During a lunch observation on February 5, 2015 the dietary aide was observed thickening soup without a recipe. In an interview with the dietary aide it was shared they were thickening cream of mushroom soup for a resident who required honey thick fluids. It was confirmed by the dietary aide that there was no recipe and they were determining thickness based on visual observation. In an interview with the Nutrition Manager on February 12, 2015 it was confirmed there were no standardized recipes for thickened soups. (Inspector #583) [s. 72. (2) (c)]

2. The licensee failed to ensure that menu substitutions were documented on the production sheets.

A) During a lunch observation on January 28, 2015 on Willoughby Hall unit, the menu and show plate choice was potato dollar chips and residents were provided hash browns. On February 5, 2015 on Orchards unit the menu choice was Greek salad and residents were provided romaine, tomato and cucumber salad. On February 6, 2015 on Lundy's Lane unit the menu choice was a bun and residents were provided slices of sandwich bread. In an interview with the cook on February 10, 2015 it was verified that potato dollar chips, feta for Greek salad and buns required substitution due to food products not being available. A record review of the production sheets for January 28, February 5 and February 6, 2015 showed no documented menu substitutions. In an interview with the Dietary Manager on February 10, 2015, it was confirmed that menu substitutions were not being documented on the production sheets. (Inspector #583) [s. 72. (2) (g)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, was kept confidential in accordance with that Act.

A) On February 12, 2015, registered staff confirmed that the medication pouches identifying residents and their prescribed medications, were disposed off with the regular garbage and not separated to ensure their personal information was protected. (Inspector #130) [s. 3. (1) 11. 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 every residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, is kept confidential in accordance with that Act, to be implemented voluntarily.

WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy "Sec. 8.6 Use of Butterfly Needle for Intermittent Subcutaneous Injection" indicated: "Remove needle form syringe and attach syringe by twisting onto clave. Slowly inject medication into system. Untwist syringe to remove from clave".

An identified resident had a physician's order to receive a specified medication by injection via a subcutaneous butterfly. On an identified date at a specified time Inspector #130 observed that the RPN removed the clave with luer lock attached to the butterfly, cleansed the open port with an alcohol wipe, removed the needle from the syringe containing the medication, attached the syringe to the open port and injected the medication into the system. The syringe was then removed from the open port, the area

was cleansed and then the clave adapter was reattached. The ADOC and the DOC confirmed the RPN should not have removed the clave as this created an open port. The staff should have attached the syringe directly to the clave as per the home's policy. (Inspector #130)

B) The home's policy "Section 4.16, Skin and Wound dated October 2013" indicated: i) For wounds where the stage is undeterminable, the interdisciplinary team will refer to Occupational Therapist and/or Physiotherapist for positioning and seating assistance.

A review of an identified resident's clinical record indicated that they exhibited impaired skin integrity to a specified area, which had been present since 2014. A review of the resident's clinical record over a specified time period from 2014 until 2015, indicated that no referral to the Occupational Therapist and/or Physiotherapist for positioning and seating assistance had been completed. An interview with the DOC confirmed that no referral had been completed and that the home had not complied with their policy. (Inspector 214)

C) The Manufacturer's Instructions for the application of Wheelchair Seatbelts directed staff to "Secure the seatbelt across the patients hips firmly so you can fit only two fingers between the seatbelt and the patient's body". The home confirmed it was the expectation that staff follow these instructions when applying seatbelts.

On January 28, 2015, an identified resident was observed in their wheelchair with a front fastening seatbelt applied. The device was loose enough that it created at least a five finger width spread between the device and the resident's abdomen. Registered staff assessed the device and confirmed it was too loose. (Inspector #130) [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 instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) A review of an identified resident's clinical record indicated that they exhibited impaired skin integrity to a specified area, which had been present since 2014. A review of the resident's assessments in PCC indicated that weekly re-assessments of the affected area were only completed on four identified dates over a specified time period in 2014. An interview with the Documentation Nurse confirmed that the resident was not reassessed at least weekly by a member of the registered nursing staff. (Inspector #214)

B) A review of an identified resident's clinical record indicated that they exhibited impaired skin integrity to a specified area, which had been present since 2014. A review of the resident's assessments in PCC from 2014 to 2015, indicated that weekly re-assessments of the affected area were only completed on seven occasions during that time period. An interview with the DOC confirmed that the resident was not reassessed at least weekly by a member of the registered nursing staff. (Inspector #214)

C) A review of another identified resident's clinical record indicated that they exhibited impaired skin integrity to two specified areas, which had been present since 2014. A review of the PCC assessments completed over a time period in 2014 until 2015, indicated that weekly re-assessments of the affected area were only completed on 12 occasions during the specified time period. An interview with the DOC confirmed that the resident was not reassessed at least weekly by a member of the registered nursing staff. (Inspector #214) [s. 50. (2) (b) (iv)]

2. The licensee failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

A) A review of another identified resident's clinical record indicated that they had impaired skin integrity to an identified area, which had been present since 2014. The resident's written plan of care dated in 2015, indicated that the resident was on a turning and repositioning program; was dependent on staff for repositioning and was to be turned and repositioned every one to two hours. A review of the "turned and repositioned" task completed in the POC documentation system was completed from a specified time period in 2015 and indicated that on six occasions during this time period, the resident was turned and repositioned only once on each of those dates. On a number of other identified dates in 2015, the resident was turned and repositioned only twice on each of those dates and on two other identified dates in 2015, the resident was turned and repositioned only three times on each of those dates. An interview with front line nursing staff confirmed that the resident was dependent on staff for repositioning and that the resident was not turned and repositioned as required. (Inspector #214) [s. 50. (2) (d)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the Registered nursing staff, if clinically indicated and to ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, to be implemented voluntarily.

WN #6: 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 failed to ensure that a response in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations was provided to Residents' Council.

A) In an interview with the President of Residents' Council on February 11, 2015, it was shared that the Council did not receive a response in writing within 10 days from the licensee when concerns or recommendations are brought forward at Residents' Council. A review of the Resident Council Agenda, Meeting Minutes and Issues/Concern template for August, September,October, November showed some responses were provided to Residents' Council in writing at the following meetings approximately 30 days later. In an interview with the DOC on February 11, 2015, it was confirmed that a response was not provided to Residents' Council in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations and there were response that remained outstanding. (Inspector #583) [s. 57. (2)]

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 response in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations is provided to Residents' Council, to be implemented voluntarily.

WN #7: 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 has failed to ensure that 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.

A) A review of the Family Council minutes from September – November 2014, was completed. A memo that was included in the October 2014 minutes indicated that it had been common practice within the Family Council to have responses to non-urgent concerns given at the next Family Council meeting and that it was being proposed that all Family Council urgent concerns receive a response within 10 days but all non-urgent matters continue to receive responses at the next Family Council meeting. An interview with the SSC confirmed that Family Council meetings were conducted on a monthly basis and that not all concerns or recommendations made by the Family Council were responded to within 10 days, in writing. (Inspector #214) [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if the 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, to be implemented voluntarily.

WN #8: 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,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

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. The licensee failed to ensure that the menu cycle was reviewed by Residents' Council.

A) In an interview with the President of Residents' Council on February 11, 2015, it was shared that the menu cycle was not reviewed by Residents' Council. In a review of the Residents' Council meeting minutes from January 2014 to present it was not identified that the home's menu had not been reviewed. In an interview with the assistant to Residents' Council on February 11, 2015, it was confirmed that the menu cycle was not reviewed with Residents' Council in 2014. (Inspector #583) [s. 71. (1) (f)]

2. The licensee failed to ensure that the planned menu items were offered to residents at each meal.

A) A review of the plan of care for an identified resident identified they were on a specified diet. In an interview with the resident in 2015 they shared they were regularly not offered an alternative entree choice. During a lunch observation on February 5, 2015, the resident was offered a specific entree by the PCP. In an interview with the dietary aide and the PCP it was identified that a specific entree was the alternative entree choice for the resident, but this information was not communicated to the nursing staff. In an interview with the nutrition manager on February 5, 2015 it was confirmed that the resident was not offered their planned menu items at lunch. (Inspector #583) [s. 71. (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 the menu cycle is reviewed by Residents' Council and to ensure that the planned menu items are offered to residents at each meal, to be implemented voluntarily.

WN #9: 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: 1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that weekly menus were communicated to residents.

A) During an observation on Orchards unit on February 5, 2015, it was observed that the weekly menu was not communicated to residents. In an interview with the Nutrition Manager it was confirmed that the expectation was that the weekly menus were to be posted on the board on each resident unit and the weekly menu was not posted on Orchards unit. (Inspector #583) [s. 73. (1) 1.]

2. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by Residents' Council.

A) In an interview with the president of Residents' Council on February 11, 2015, it was shared that the meal and snack times were not reviewed by Residents' Council. In a review of the Residents' Council meeting minutes from January 2014 to present it was not identified that the home's meal and snack times had been reviewed. In an interview with the assistant to Residents' Council on February 11, 2015 it was confirmed that the home's dining and snack service had not included a review of the meal and snack times by Residents' Council in 2014. (Inspector #583) [s. 73. (1) 2.]

WN #10: 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 failed to ensure that they sought the advice of Residents' Council to develop, carry out and act on the results of the satisfaction survey.

A) In an interview with the President of Residents' Council on February 11, 2015, it was shared that the licensee did not seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results. During a review of the 2014 meeting minutes from January to December and an interview with the Residents' Council assistant on February 11, 2015, it was confirmed that the advice of the Residents' Council was not sought in the developing and carrying out of the survey, and it acting on its results. (Inspector #583) [s. 85. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

A) On February 12, 2015, it was observed that discontinued controlled substances were stored in a locked stationary cupboard within a locked medication room. Although the cupboard containing the medication was locked, pulling on the door handles created a gap underneath, which allowed the Inspector to slide a hand in the cupboard and remove a narcotic card. The DOC confirmed the stationary cupboard was not double locked and verified that the locking mechanism on the doors was ineffective. (Inspector #130) [s. 129. (1) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
7. The resident's ability to have money deposited in a trust account under section 241 of this Regulation. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the admission package included trust account information.

A) A review of the Long Term Care Homes (LTCH) Licensee Confirmation Checklist Admission Process, completed by DOC was done and identified the admissions package did not include trust account information. In an interview with the DOC on February 12, 2015, it was confirmed that the admission package did not provide information on the residents' ability to have money deposited in a trust account. (Inspector #583) [s. 224. (1) 7.]

Issued on this 25th day of May, 2015

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

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) :	GILLIAN TRACEY (130), CATHY FEDIASH (214), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2015_323130_0002
Log No. / Registre no:	H-001833-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 7, 2015
Licensee / Titulaire de permis :	BELLA SENIOR CARE RESIDENCES INC. 1000 FINCH AVENUE WEST, SUITE 901, TORONTO, ON, M3J-2V5
LTC Home / Foyer de SLD :	BELLA SENIOR CARE RESIDENCES INC. 8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BRENDA HARKER

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant:
2013_202165_0011, CO #001;
2014_191107_0016, CO #001;

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 prepare, submit, and implement a plan that ensures the plan of care is provided to residents, as specified in their plan related to activities, bathing, medication administration related to pain management, lifts and transfers, fluid consumption and supplements, for all residents including #008, #010, #012, #014, #401, #402 and #403. The plan shall include: dates and quality management activities used to ensure compliance. The plan shall be submitted to Long-Term Care Homes Inspector Gillian Tracey, Gillian.Tracey@ontario.ca, by May 20, 2015.

Grounds / Motifs :

1. Previously issued on September 21, 2011 as VPC, January 10, 2013, as WN, August 21, 2013, as CO and September 6, 2013 as CO.

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

A) A review of an identified resident's written plan of care dated in 2015, indicated under activities that the resident was dependent on staff for activities and that staff would attempt to provide one to one activities two times per month. An interview with the RSSM indicated that attendance to activities was documented in the resident's progress notes under "Recreation Note". A review of these progress notes from a specified time period in 2014 until a time period in 2015 indicated that the resident received only one visit of a one to one activity in a specific month 2014. An interview with the RSSM indicated that one to one activities were provided during the Friendly Visits program and that weekly, the

Comfort Care Coordinator would also provide one to one activities. A review of the one to one visits conducted by the Comfort Care Coordinator indicated that the resident had not received any one to one visit's nor was there any documentation of attempt's made to provide one to one visits to the resident. A review of the home's activity calendars from the identified time period in 2014 and 2015 indicated that the Friendly Visits programs were offered during these months on three out of the six resident home areas; however, they were not offered on the home area that the resident resided on. An interview with the RSSM confirmed that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

B) During an interview in 2015 an identified resident shared they were not bathed twice weekly by the method of their choice. A review of their plan of care indicated they were to receive two showers per week per their preference. The bathing records were reviewed for a one month period in 2015 and it was documented on resident on their scheduled shower days three identified dates that the resident received a bed bath and on a fourth and fifth date during the identified month staff documented "not applicable". In an interview with the resident they confirmed that on three of the identified dates they received received a bed bath and it was their preference to have a shower and on two other dates during the identified time period they were not bathed. A review of the plan of care indicated the resident was able to make decisions about choice and preferences and had a cognitive performance scale assessed at two. In an interview with the Personal Support Worker (PSW)it was confirmed the resident would be able to provide an accurate recall of bathing provided. In an interview with the DOC on an identified date in 2015 it was confirmed that the resident was not showered at minimum twice per week per their preference. (Inspector #583)

C) A review of an identified resident's written plan of care dated in 2014, indicated that the resident was at high nutritional risk and that staff were to notify the Registered Dietitian (RD) if the resident consumed less than a specified volume of fluid for three consecutive days. A review of the "fluid intake" task in the Point of Care (POC) documentation system that was completed over a specified period in 2015, indicated that consecutively over a number identified time periods, the resident had consumed less than the specified volume of fluid daily. A review of the resident's clinical record indicated that the RD had not reassessed the resident when they consumed less than the specified volume of fluid for three consecutive days. An interview with registered staff confirmed that

no dietary referrals had been completed for the dates identified and that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

D) A review of an identified resident's written plan of care dated in 2014, indicated that the resident was at high nutritional risk and that staff were to notify the RD if the resident consumed less than 50 percent of their meal for three consecutive days. A review of the "amount eaten" task in the POC documentation system that was completed over a specified time period in 2015, indicated that on at least six occasions the resident consumed less than 50 percent of their meals. A review of the resident's clinical record indicated that the RD had not reassessed the resident when they consumed less than 50 percent of their meal for three consecutive days. An interview with registered staff confirmed that no dietary referrals had been completed for the dates identified and that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

E) A review of another identified resident's written plan of care dated 2015, indicated that the resident was at high nutritional risk and that staff were to notify the RD if the resident consumed less than a specified volume of fluid for three consecutive days. A review of the "fluid intake" task in the POC documentation system that was completed from over a period of time in 2015, indicated that consecutively over a period of time in 2015, the resident consumed less than the specified volume of fluid daily. An interview with the DOC confirmed that staff did not notify the RD when the resident consumed less than the specified volume for three consecutive days and that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

F) A review of another identified resident's written plan of care in 2015, indicated that the resident was at high nutritional risk and that staff were to notify the RD if the resident consumed less than 50 percent of their meal for three consecutive days. A review of the "amount eaten" task in the POC documentation system that was completed over a specified time period in 2015, indicated that consecutively over a specified time period in 2015 and consecutively over another time period in 2015, the resident consumed less than 50 percent of their meals. An interview with the DOC confirmed that staff did not notify the RD when the resident consumed less than 50 percent of their meal for three consecutive days and that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

G) A review of an identified resident's clinical record indicated they had impaired skin integrity to an identified area in 2014 to a specified date in 2015, for which the NP prescribed non-medicated treatment orders. On an identified date in 2015, the physician ordered a narcotic analgesic, to be administered prior to treatments. A review of the resident's E-MAR over a one month time period in 2015, indicated that on two identified dates, the resident received dressing changes to the affected area; however, no administration of the narcotic analgesic was documented as having been given. A review of the Narcotic and Controlled Substance Administration Record on the identified dates, indicated that Dilaudid was not recorded as being administered. An interview with registered staff indicated that the medication had not been administered on the identified dates as the affected area had only been checked and not changed. The registered staff confirmed that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector# 214)

H) On a specific date in 2015, an identified resident was found in their washroom unattended sitting on the toilet in a sling which was attached to the sit to stand lift. Inspector #583 requested immediate assistance from a Registered Practical Nurse (RPN). A review of the plan of care of the identified resident indicated they required extensive assistance from two staff for transfers using the sit to stand lift and extensive assistance from two staff members for toileting due to their diagnosis. The RPN verified the resident was left unattended on the toilet, attached to the sit to stand lift and that toileting and transferring plan identified in the plan of care was not provided as specified in the plan. (Inspector #583)

I) A review of the plan of care for an identified resident indicated they were at moderate nutrition risk, on a regular minced textured diet and were to receive a supplement with meals. During a lunch observation on February 6, 2015 in an identified dining room it was noted that the resident's table setting was set with cutlery and poured beverages. Lunch service began at 1200 hours. In an interview with the dietary aide and RPN at 1245 hours it was confirmed that lunch service had finished, all residents meals had been plated and medication pass nutrition supplements had been provided. At 1250 hours the identified resident was observed by Inspector #583 and the DOC, to be sitting on their unit. In an interview with the Nutrition Manager, who was present during the dining observation in the specified dining room and the DOC, it was confirmed the resident was not offered a regular, minced texture meal or their ordered supplement at lunch as specified in the plan of care. (Inspector #583)

J) A review of the plan of care for an identified resident indicated the resident was to be provided a specific beverage at lunch. During a lunch observation on February 6, 2015 the resident was not offered the specific beverage. In an interview with the PCP and the dietary aide on February 6, 2015 it was confirmed that the resident was not provided the specific beverage as specified in their plan. (Inspector #583) [s. 6. (7)]
(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_191107_0016, CO #002;

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 outlines how the home will ensure that standardized recipes and production sheets are in place to direct staff in the preparation of the planned menu, that they are followed and that menu substitutions are documented on productions sheets. The plan shall include time frames and quality management strategies used to ensure compliance. The plan shall be submitted to Long-Term Care Homes Inspector Gillian Tracey, Gillian.Tracey@ontario.ca, by May 20, 2015.

Grounds / Motifs :

1. Previously issued non compliance on September 24, 2012, VPC and September 2, 2014, CO.

The licensee failed to ensure that there were production sheets for all menus.

A) A record review of the week two menu production sheets from February 2 to February 8, 2015 showed the production sheets had not been completed. In an

interview with the cook and the Nutrition Manager on February 10, 2015 it was confirmed that there were no completed production sheets for breakfast, lunch and dinner from February 2 to February 8, 2015. (Inspector #583)

The licensee failed to ensure the food production system provided standardized recipes for all menus.

During a lunch observation on February 5, 2014 the Dietary Aide (DA) was observed thickening soup without a recipe. In an interview with the DA it was shared they were thickening cream of mushroom soup for a resident who required honey thick fluids. It was confirmed by the DA that there was no recipe and they were determining thickness based on visual observation. In an interview with the Nutrition Manager on February 12, 2015 it was confirmed there were no standardized recipes for thickened soups. (Inspector #583)

The licensee failed to ensure that menu substitutions were documented on the production sheets.

During a lunch observation on a) January 28, 2015 on Willoughby Hall unit the menu and show plate choice was potato dollar chips and residents were provided hash browns b) February 5, 2015 on Ochards unit the menu choice was Greek salad and residents were provided romaine, tomato and cucumber salad c) February 6, 2015 on Lundy's Lane unit the menu choice was a bun and residents were provided slices of sandwich bread. In an interview with the cook on February 10, 2015 it was verified that potato dollar chips, feta for Greek salad and buns required substitution due to food products not being available. A record review of the production sheets for January 28, February 5 and February 6, 2015 showed no documented menu substitutions. In an interview with the Dietary Manager on February 10, 2015 it was confirmed that menu substitutions were not being documented on the production sheets. (Inspector #583)
(583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2015

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
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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 7th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN TRACEY

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