Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 23, 24, 27, 29, 2012	2012_038197_0022	Complaint

Licensee/Titulaire de permis

CARVETH NURSING HOME LIMITED
375 JAMES STREET, GANANOQUE, ON, K7G-2Z1

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

CARVETH CARE CENTRE
375 JAMES STREET, GANANOQUE, ON, K7G-2Z1

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nutrition Manager, the Registered Dietitian, the Environmental Manager, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed the Spring/Summer 2012 meal and snack menus, the Nutritional Summary of the Spring/Summer 2012 menu, minutes from the Menu Meeting for Menu Planning and Approval for 2012 Spring and Summer Menus, Resident Council meeting minutes since May 2012, resident room temperatures taken the week of May 2, 2012, took a tour of the home including all air conditioned areas and observed part of a lunch meal.

The following Inspection Protocols were used during this inspection:

Food Quality

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following subsections:

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 following finding indicates that the licensee has failed to comply with LTCHA 2007, s. 57(2) in that the licensee did not respond to the Resident's Council in writing within 10 days in response to a concern brought forward about the operation of the home.
During an interview on August 27, 2012 the Administrator stated that he had not responded in writing within 10 days to the Resident Council's dietary concerns from their August 7, 2012 meeting.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The following findings indicate that the licensee has failed to comply with O. Reg. 79/10, s. 71(1)(f) in that the home's menu cycle was not reviewed by the Resident's Council.
During an interview on August 24, 2012, Resident #1 stated that he/she did not recall the Resident's Council having the chance to review the Spring/Summer 2012 menu.
During an interview with the Nutrition Manager on August 27, 2012, she stated that she had not presented the Spring/Summer 2012 menu to the Resident's Council for review, but rather held a separate meeting for residents to review the menu.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with O. Reg. 79/10, s. 72(2)(f) in that a menu substitution was not communicated to all residents.
During an interview on August 24, 2012, Resident #1 stated that at a recent supper meal he/she ordered fish and chips and received crab cakes instead. Resident #1 further stated that the crab cakes were presented as the fish that was on the menu and that he/she was not told by the staff that they were really crab cakes. Resident #1 expressed being very upset and stated that he/she did not eat dinner because of this.
During an interview with the Nutrition Manager on August 27, 2012 she stated that on this particular day the home ran out of the fish that was on the menu due to high demand and that the cook substituted crab cakes for the fish.

Issued on this 29th day of August, 2012

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

Jessica Pattison, RD