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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 19, 2018	2018_740621_0010	005250-18	Resident Quality Inspection

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

JULIE KUORIKOSKI (621), AMY GEAUVREAU (642), CHAD CAMPS (609), LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 9 - 13, 2018.

The following additional intakes were inspected during this Resident Quality Inspection:
- An intake related to compliance order #001, issued during inspection #2017_655679_0008, regarding s.6(4) plan of care;
- An intake related to compliance order #002, issued during inspection #2017_655679_0008, regarding s.135(2) medication incident documentation;
- An intake related to compliance order #003, issued during inspection #2017_655679_0008, regarding s.131(2) medication administration;
- An intake related to compliance order #001, issued during inspection #2017_657681_0018, regarding s.11(2) dietary services;
- Two Critical Incidents (CIs) related to medication management;
- Two CIs related to falls prevention and management; and
- One CI related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Directors of Care (Co-DOCs), interim Food Services Supervisor (FSS), Regional Nutrition Manager, Registered Dietitian (RD), Restorative Care Coordinator (RCC), Staff Education Coordinator, Staff Educator, Environmental Services Manager (ESM), a Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, a Food Service Cook, a Housekeeping Aide, family member and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health records, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **4 WN(s)**
- **2 VPC(s)**
- **1 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. 131. (2)	CO #003	2017_655679_0008	609
O.Reg 79/10 s. 135. (2)	CO #002	2017_655679_0008	609
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2017_655679_0008	642

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. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order CO#01 from inspection #2017_657681_0018 served on January 10, 2018, with a compliance date of March 30,

2018.

The licensee was ordered to:
"The licensee shall prepare, submit, and implement a plan for ensuring that all residents are provided with food and fluids that are safe, adequate in quantity, nutritious, and varied. The plan shall include, but not limited to include the following:

a) Review all of the residents in the home who are receiving a texture modified diet to ensure that food and beverage choices, including snack choices, on the planned menu are appropriate and safe for each of these residents to consume. Documentation related to this review must be maintained.
b) Educate all dietary staff, PSWs, RPNs, and RNs about appropriate food choices for residents receiving texture modified diets.
c) Ensure that nursing and dietary staff have clear and specific instructions about residents' dietary requirements readily accessible during all meal and snack services.
d) Educate dietary staff about the principles of safely storing food and beverages."

The licensee completed part a) and d) in CO#001.

The licensee failed to complete part b), and c) of CO#001.

1. In part "b" of the order, the licensee was ordered to educate all dietary staff, PSWs, RPNs, and RNs about appropriate food choices for residents receiving texture modified diets.

During an interview, Staff Education Coordinator (SEC) #136 reported to Inspector #621 that with respect to part "b" of the compliance order, they were responsible for rolling out a three part education package and corresponding quizzes, developed through an external resource, and provided through the home's Regional Nutrition Manager to the home's PSW, RPN and RN staff. The education included a two page handout on topics including therapeutic menus, dysphagia and safe feeding practices, and the International Dysphagia Diet Standardization Initiative (IDDSI). Additionally, SEC #136 identified that they provided the same education package for the previous Food Services Supervisor (FSS) #134 to complete with all dietary staff within the required timelines. When the Inspector inquired as to who was tracking completion of this education, SEC #136 indicated that they had kept lists of who had completed the training from dietary, as well as PSW, RPN and RN staff, up to the compliance order (CO) due date of March 30, 2018. When the Inspector inquired as to whether all of the required staff were trained by

the CO due date, SEC #136 reported that there were still three PSW staff who had not yet returned copies of their completed quizzes from the three part education package, and had completed shifts in the home after March 30, 2018.

During a review of the staff education lists for dietary, PSW, RPN and RN staff, with respect to completion of the three part education package and corresponding quizzes, as provided by SEC #136, Inspector #621 identified one dietary, one RPN and nine PSW staff were recorded as being incomplete with the required education.

During a subsequent interview with SEC #136, they confirmed with Inspector #621 that one out of 18 (five per cent) dietary staff; one out of 18 (five per cent) RPN staff, and nine out of 67 (13 per cent) PSW staff, had not completed the required education by the CO due date.

During an interview with Food Services Supervisor (FSS) #133, they informed Inspector #621 that they had just started in an interim role as the FSS for the home. FSS #133 identified to the Inspector that they had not been made aware by the previous FSS #134 that there was an outstanding MOHLTC order for which they would be required to follow up to ensure completion of required elements. Additionally, FSS #133 confirmed that they were unable to verify for the Inspector which dietary staff (if any) had completed the three part education exercise and corresponding quizzes related to the home's plan of action for part "b" of the order, to ensure all dietary staff had been educated.

During an interview with Co-Director of Care (Co-DOC) #101, they reported to Inspector #621 that SEC #136 was responsible for completing the required education related to the compliance order with PSW, RPN and RN staff. Co-DOC #101 however, reported that they were aware that PSWs #148 and #149 had not completed the education by the CO due date as SEC #136 had asked them to assist in getting these two PSW staff to complete the education, and they had not followed on this task due to their workload. Additionally, Co-DOC #101 verified that seven of nine PSW staff who were identified by SEC #136 to have not completed the three part education package and corresponding quizzes, had since worked one or more shifts after March 30, 2018.

During an interview with the Administrator, they reported to Inspector #621 that it was their expectation that FSS #134 had completed training of their dietary staff, and that SEC #136 had completed training of all PSW, RPN and RN staff by March 30, 2018, and that if there had been issues FSS #134 and SEC #136 would have notified them to trouble shoot the situation before the order due date had passed.

2. In part "c" of the order, the licensee was ordered to ensure that nursing and dietary staff had clear and specific instructions about residents' dietary requirements readily accessible during all meal services.

On the morning of April 11, 2018, Inspector #621 observed and took copies of Home Areas #1 and #2 Master Diet Lists (MDL) located at their respective dining room serveries. On review of the Home Area #1 MDL sheets dated March 14, 2018, and Home Area #2 MDL diet sheets dated March 6, 2018, the Inspector noted that under the "Special Instructions" category for all residents, regardless of whether they were on regular and texture modified diets, it read "see care plan for additional eating instructions".

During an interview with Cook #140, they reported to Inspector #621 that they referred to the MDL diet sheets updated by the FSS to know the dietary requirements of each resident they were providing meal service for. Cook #140 identified that FSS #134 had made changes to the MDL diet sheets over the previous quarter and removed "lots of information" that they relied on to ensure residents were being provided what was consistent to their dietary needs. Cook #140 indicated that what replaced the details on the MDL diet sheets was a note in the special instructions section, which told staff to see the care plan for additional eating instructions. Cook #140 reported that they did not have access directly to resident care plans like the nursing staff or the dietitian had on the units, and that they had no idea what information was on the eating care plan that was no longer listed on the MDL diet sheet, which created potential risk for providing or omitting things from meal service that a resident may require.

During interviews with PSWs #145 and #146, and RPN #112, they reported to Inspector #621 that they obtained information about a resident's dietary needs from the MDL diet sheet during meal service. They identified to the Inspector that the MDL however did not have much information on it compared to a few months back as the previous FSS #134 had changed the MDL's to have less information, which led to a need for nursing staff to now refer to the resident's care plan on the electronic health record for this information. Additionally, they stated that they did not have time to check resident care plans or Kardex information for further instructions, and that the change that occurred with the MDL diet sheets was increasing risk that things that had been care planned for residents was being missed at meal times.

During an interview with the Administrator, they reviewed with Inspector #621 diet sheets

for resident #009, #010 and #011 dated from two specific dates in March 2018. From this review, they confirmed to the Inspector that each of the three residents required a specific type of therapeutic diet, and that under a specific section of the diet sheets, it referred staff to review a specific care plan for further instructions. The Administrator, reported to the Inspector that they had completed an audit in the previous two weeks, and had observed the reference on the diet sheets to refer to the resident's care plan for more information. The Administrator reported that they proceeded to direct former FSS #134 to remove the instructions in a specific section of the diet sheet. The Administrator confirmed that the diet sheets for resident #009, #010 and #011 reviewed by them with the Inspector continued to have the information that they directed FSS #134 to remove, and did not mirror the information on their respective care plans with a specific focus. Additionally the Administrator indicated that all relevant information that was on a specific care plan should have been on the diet sheets of each resident to mitigate risk that important details concerning each residents dietary care needs were not missed. [s. 11. (2)] (621)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 (CI) report was submitted to the Director on a specific day in September 2017, related to an incident which resulted in injury of resident #006.

The CI report had been amended by the Director of Care (DOC) on another day in September 2017, which indicated that: a) resident #006 did not have a specific safety device in place at the time of the incident and b) the residents care plan stated that staff were to ensure the residents safety device was in place and functioning when engaged in specific activities.

Inspector #642 interviewed RPN #13, who had assessed resident #006's condition at the time of the incident. RPN #131 stated to the Inspector that resident #006's safety device was not function at the time of the incident, and upon assessment of the resident, they identified that there had been no safety device in place as required. During subsequent interviews with both RPN #131, and RN #121, they stated to Inspector #642 that staff were expected to provide care to residents as set out in their plan of care.

Inspector #621 reviewed the home's policy titled, "Resident Rights, Care and Services-Plan of Care" last revised in March 2018, which identified under the section of Nursing and PSW's, that staff were to ensure that care was provided to the resident as specified in the plan of care.

During an interview with Co-Director #130, they reported to Inspector #642 that the care plan for resident #006 which was in effect at the time the incident that occurred on a specific day in September 2017, identified that a specific safety device was to be in place during a specific activity. Co-Director #130 indicated that staff should have ensured that resident #006 had their safety device in place and functioning, as their plan of care directed.

As resident #006's care plan indicated that they were to have their safety device in place the time of the incident, the licensee failed to comply with s.6(7). [s. 6. (7)] (642)

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 has failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs.

Inspector #609 observed the medication cart on a specific home area, the emergency controlled substances storage box on another specific home area, as well as the home's government medication stock room. In two of three (or 66 per cent) of the medication storage areas, there contained expired medications.

A review of the home's policy titled "Drug Destruction: Non-Controlled Substances" with no revision date, required all expired medications be removed from the active medication supply.

During an interview with RN #109, they verified to Inspector #609 that the identified medications were expired and immediately removed them from the active medication supply. The RN indicated that night shift registered staff were responsible for ensuring that medications were not expired.

During an interview with Co-DOC #101, they verified to Inspector #609 that expired medications should not have been the active medication supply, and outlined how it was not just night shift registered staff but all registered staff's responsibility on all shifts to ensure that their assigned residents' medications were not expired.

As the home, at the time of inspection, had expired medications identified within their active medication supply, the licensee failed to comply with s.129(1)(a). [s. 129. (1) (a)] (609)

2. The licensee has 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.

Inspector #609 observed the medication cart on a specific home area, and the emergency controlled substances storage box on another specific home area, and found that in one of two (or 50 per cent) of the storage areas there were controlled substances that were not stored in a double locked stationary cupboard in a locked area, or in a separate locked area within the locked medication cart.

When Inspector #609 asked to see the emergency controlled substances storage box, RN #109 unlocked the medication room in a specified home area, opened a single lock on the stationary cupboard, and then took out a locked removable metal box. Inside the metal box, controlled substances were observed.

A review of the home's policy titled "Resident Rights, Care and Services- Medication Management-Narcotics and Controlled Substances" last revised in October 2013, indicated that narcotics were to be stored in a permanently affixed cabinet, under double lock at all times.

During an interview with Co-DOC #101, a review of the Regulation, the home's Medication Management policy and the Inspector's observations were conducted. From the review, the Co-DOC verified to the Inspector that the stationary cupboard housing the

emergency controlled substances storage box was not double-locked.

During an interview with the Administrator, they outlined how all controlled substances within the emergency storage box in a specific home area had been transferred to the locked cupboard within the locked medication cart, and that this would be the home's new process for storage of their emergency controlled substances.

As the home, at time of inspection, did not have their emergency controlled substances storage box in a specific home area's medication room stored in a separate double-locked stationary cupboard in a locked area, the licensee failed to comply with s.129(1)(b). [s. 129. (1) (b)] (609)

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 drugs are stored in an area or a medication that complies with manufacturer's instructions for the storage of the drugs; and 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the residents' health condition and for which the resident was taken to the hospital.

A Critical Incident (CI) report was submitted to the Director on a day in August 2017, related to an incident which occurred on a specific day in July 2017, which resulted in resident #005 sustaining injuries and being sent to hospital.

Inspector #642 reviewed resident #005's health care records which identified that the resident had returned from hospital at a specific time on a specified day in July 2017, and that RPN #108 had informed Co- Director of Care (Co-DOC) #101 about resident #005's return and condition. Further review of the residents' health record identified that Co-DOC #101 had documented later on the same day when the incident occurred, information which identified the injuries resident #005 sustained.

Inspector #642 interviewed RPN #108, who confirmed to the Inspector that they were in the home on the day of the incident when resident #005 returned from hospital, and that they had informed Co-DOC #101 at that time of resident #005's return from hospital, of their injuries.

Inspector #642 interviewed Co-DOC #101, who stated that they had been informed of resident's #005 significant health change after the incident, along with their subsequent return from the hospital later that day. Co-DOC #101 confirmed to the Inspector that they did not report the incident to the Director within one business day after the incident, but instead reported the incident to the Director three days after.

Inspector #642 reviewed the home's policy titled, "Resident Rights, Care and Services-Reporting and Complaints-Critical Incident Reporting" last revised in May 2015, which identified that the licensee was to ensure that the Director was informed within one day of any injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the residents health condition.

As the home reported the incident three days after resident #005 sustained injuries from an incident which resulted in a significant change in their health status, the licensee failed to comply with s.107(3)4 with regards to the requirement to report within one business day. [s. 107. (3) 4.] (642)

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

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Issued on this 24th day of April, 2018

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621), AMY GEAUVREAU (642), CHAD CAMPS (609), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2018_740621_0010
Log No. / No de registre :	005250-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 19, 2018
Licensee / Titulaire de permis :	Valley East Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Elizabeth Centre 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

To Valley East Long Term Care Centre Inc., 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)

Linked to Existing Order / Lien vers ordre existant: 2017_657681_0018, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Order / Ordre :

The licensee must be compliant with s.11(2) of the LTCHA.
Specifically, the licensee must:
a) Ensure that all dietary staff, PSWs, and RPNs who have not completed education with regards to providing safe and appropriate food choices for residents that require texture modified diets, have completed this training, with supporting documentation;
b) Ensure that during meal service, nursing and dietary staff have readily available, instructions outlining each resident's dietary requirements which are clear, specific and accurate with respect to each residents' plan of care; and
c) Ensure that the Administrator and, in their absence, management designate (s) are prepared to speak to, and have documented evidence to support the requirements of part a) and b) of this order, by the compliance order due date.

Grounds / Motifs :

1. 1. The licensee has failed to comply with compliance order CO#01 from inspection
#2017_657681_0018 served on January 10, 2018, with a compliance date of March 30, 2018.

The licensee was ordered to:
"The licensee shall prepare, submit, and implement a plan for ensuring that all residents are provided with food and fluids that are safe, adequate in quantity, nutritious, and varied. The plan shall include, but not limited to include the following:

a) Review all of the residents in the home who are receiving a texture modified diet to ensure that food and beverage choices, including snack choices, on the planned menu are appropriate and safe for each of these residents to consume. Documentation related to this review must be maintained.
b) Educate all dietary staff, PSWs, RPNs, and RNs about appropriate food choices for residents receiving texture modified diets.
c) Ensure that nursing and dietary staff have clear and specific instructions about residents' dietary requirements readily accessible during all meal and snack services.
d) Educate dietary staff about the principles of safely storing food and beverages."

The licensee completed part a) and d) in CO#001.

The licensee failed to complete part b), and c) of CO#001.

1. In part “b” of the order, the licensee was ordered to educate all dietary staff, PSWs, RPNs, and RNs about appropriate food choices for residents receiving texture modified diets.

During an interview, Staff Education Coordinator (SEC) #136 reported to Inspector #621 that with respect to part “b” of the compliance order, they were responsible for rolling out a three part education package and corresponding quizzes, developed through an external resource, and provided through the home’s Regional Nutrition Manager to the home’s PSW, RPN and RN staff. The education included a two page handout on topics including therapeutic menus, dysphagia and safe feeding practices, and the International Dysphagia Diet Standardization Initiative (IDDSI). Additionally, SEC #136 identified that they provided the same education package for the previous Food Services Supervisor (FSS) #134 to complete with all dietary staff within the required timelines. When the Inspector inquired as to who was tracking completion of this education, SEC #136 indicated that they had kept lists of who had completed the training from dietary, as well as PSW, RPN and RN staff, up to the compliance order (CO) due date of March 30, 2018. When the Inspector inquired as to whether all of the required staff were trained by the CO due date, SEC #136 reported that there were still three PSW staff who had not yet returned copies of their completed quizzes from the three part education package, and had completed shifts in the home after March 30, 2018.

During a review of the staff education lists for dietary, PSW, RPN and RN staff, with respect to completion of the three part education package and corresponding quizzes, as provided by SEC #136, Inspector #621 identified one dietary, one RPN and nine PSW staff were recorded as being incomplete with the required education.

During a subsequent interview with SEC #136, they confirmed with Inspector #621 that one out of 18 (five per cent) dietary staff; one out of 18 (five per cent) RPN staff, and nine out of 67 (13 per cent) PSW staff, had not completed the required education by the CO due date.

During an interview with Food Services Supervisor (FSS) #133, they informed Inspector #621 that they had just started in an interim role as the FSS for the home. FSS #133 identified to the Inspector that they had not been made aware by the previous FSS #134 that there was an outstanding MOHLTC order for which they would be required to follow up to ensure completion of required elements. Additionally, FSS #133 confirmed that they were unable to verify for the Inspector which dietary staff (if any) had completed the three part education exercise and corresponding quizzes related to the home's plan of action for part "b" of the order, to ensure all dietary staff had been educated.

During an interview with Co-Director of Care (Co-DOC) #101, they reported to Inspector #621 that SEC #136 was responsible for completing the required education related to the compliance order with PSW, RPN and RN staff. Co-DOC #101 however, reported that they were aware that PSWs #148 and #149 had not completed the education by the CO due date as SEC #136 had asked them to assist in getting these two PSW staff to complete the education, and they had not followed on this task due to their workload. Additionally, Co-DOC #101 verified that seven of nine PSW staff who were identified by SEC #136 to have not completed the three part education package and corresponding quizzes, had since worked one or more shifts after March 30, 2018.

During an interview with the Administrator, they reported to Inspector #621 that it was their expectation that FSS #134 had completed training of their dietary staff, and that SEC #136 had completed training of all PSW, RPN and RN staff by March 30, 2018, and that if there had been issues FSS #134 and SEC #136 would have notified them to trouble shoot the situation before the order due date had passed.

2. In part "c" of the order, the licensee was ordered to ensure that nursing and dietary staff had clear and specific instructions about residents' dietary requirements readily accessible during all meal services.

On the morning of April 11, 2018, Inspector #621 observed and took copies of Home Areas #1 and #2 Master Diet Lists (MDL) located at their respective dining room serveries. On review of the Home Area #1 MDL sheets dated March 14, 2018, and Home Area #2 MDL diet sheets dated March 6, 2018, the Inspector noted that under the "Special Instructions" category for all residents, regardless of whether they were on regular and texture modified diets, it read "see care plan for additional eating instructions".

During an interview with Cook #140, they reported to Inspector #621 that they referred to the MDL diet sheets updated by the FSS to know the dietary requirements of each resident they were providing meal service for. Cook #140 identified that FSS #134 had made changes to the MDL diet sheets over the previous quarter and removed "lots of information" that they relied on to ensure residents were being provided what was consistent to their dietary needs. Cook #140 indicated that what replaced the details on the MDL diet sheets was a note in the special instructions section, which told staff to see the care plan for additional eating instructions. Cook #140 reported that they did not have access directly to resident care plans like the nursing staff or the dietitian had on the units, and that they had no idea what information was on the eating care plan that was no longer listed on the MDL diet sheet, which created potential risk for providing or omitting things from meal service that a resident may require.

During interviews with PSWs #145 and #146, and RPN #112, they reported to Inspector #621 that they obtained information about a resident's dietary needs from the MDL diet sheet during meal service. They identified to the Inspector that the MDL however did not have much information on it compared to a few months back as the previous FSS #134 had changed the MDL's to have less information, which led to a need for nursing staff to now refer to the resident's care plan on the electronic health record for this information. Additionally, they stated that they did not have time to check resident care plans or Kardex information for further instructions, and that the change that occurred with the MDL diet sheets was increasing risk that things that had been care planned for residents was being missed at meal times.

During an interview with the Administrator, they reviewed with Inspector #621 diet sheets for resident #009, #010 and #011 dated from two specific dates in March 2018. From this review, they confirmed to the Inspector that each of the three residents required a specific type of therapeutic diet, and that under a specific section of the diet sheets, it referred staff to review a specific care plan for further instructions. The Administrator, reported to the Inspector that they had completed an audit in the previous two weeks, and had observed the reference on the diet sheets to refer to the resident's care plan for more information. The Administrator reported that they proceeded to direct former FSS #134 to remove the instructions in a specific section of the diet sheet. The Administrator confirmed that the diet sheets for resident #009, #010 and #011 reviewed by them with the Inspector continued to have the information that they directed FSS #134 to remove, and did not mirror the information on their respective care plans with a specific focus. Additionally the Administrator indicated that all relevant information that was on a specific care plan should have been on the diet sheets of each resident to mitigate risk that important details concerning each residents dietary care needs were not missed. [s. 11. (2)] (621)

The severity of this issue was determined to be a level 2 as there was potential for harm to residents. The scope of the issue was a level 2 as it related to a pattern of incomplete education of dietary, PSW and RPN staff and a pattern of instructions relating to resident dietary requirements not being readily accessible during the dining meal service for nursing and dietary staff. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:
• Compliance order (CO) #001 issued January 10, 2018, with a compliance due date of March 30, 2018 (2017_657681_0018). (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 25, 2018

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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 19th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Julie Kuorikoski

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