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
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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
Oct 2, 2015	2015_182128_0020	019816-15	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

THE FORDWICH VILLAGE NURSING HOME
3063 Adelaide Street Fordwich ON N0G 1V0

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

RUTH HILDEBRAND (128), ALI NASSER (523), RAE MARTIN (515)

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): August 19-21, 24-26, 28, 31 and September 1-4, 2015.

This Resident Quality Inspection was done in conjunction with a Complaint Inspection, Log #007284-15 related to personal care not being provided to identified residents and resident charges.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Administrative Assistant, three Registered Nurses, two Registered Practical Nurses, one Foot Care Nurse, eight Personal Support Workers/Health Care Aides, Physiotherapist, one Physiotherapy Aide, Food Service Manager, three Dietary Aides, the Maintenance Manager and one Maintenance Worker.

The Inspector(s) also toured all resident home areas and common areas, observed residents and the care provided to them, resident-staff interactions, dining and partial snack service, medication administration, medication storage areas, posting of required information, general maintenance, cleanliness and condition of the home. Health care records and plans of care for identified residents were reviewed, as well as the home's internal investigation notes, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **16 WN(s)**
- **9 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A review of written communication from a resident's family member to the Administrator/Director of Care revealed the family member submitted a written concern regarding identified care issues.

On September 2, 2015, a review of the home's complaint logs entitled Resident/Family/Staff Concern Forms revealed there was no evidence that the following was documented for concerns identified on four of four complaints (100 per cent):
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- the final resolution, if any;
- every date on which any response was provided to the complainant and a description of the response; and
- any response made in turn by the complainant.
The complaints had four identified dates.

In an interview, the Administrator/Director of Care acknowledged that the complaint logs did not contain information in accordance with the legislation and confirmed the expectation that the documented record in the home should include all the required information.

The scope of this issue was widespread because 100 per cent of written complaints reviewed did not have written records containing all the required information. The home did not have a history of non-compliance with this regulation. The severity of the issue was determined to be a level two with potential for harm. [s. 101. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized food production system that, at a minimum, provided for the following:
-standardized recipes and production sheets for all menus;
-preparation of all menu items according to the planned menu;
-communication to residents and staff of any menu substitutions; and
-documentation on the production sheet of any menu substitutions.

A. Observation of the lunch meal, on August 19, 2015, revealed that the planned menu for week four of the spring and summer menu had been changed. The week at a glance menu indicated the planned lunch meal was minestrone soup, ham salad plate, and citrus fruit cup or grape juice, crunchy perch, sweet potato fries, creamy coleslaw, and chocolate mousse. However, the actual meal served was grape juice, sandwich plate, chocolate mousse or quiche, peas, and applesauce.

The planned supper meal for August 19, 2015, indicated it was to be a residents' choice

meal whereby the residents decided what was to be served. Nothing was identified on the week at a glance menu regarding the choice that the residents had made. The meal served was cabbage rolls, corn on the cob and strawberry bars.

The planned menu for lunch August 20, 2015, indicated that cream of mushroom soup, sliced pork with cajun mayonnaise on a kaiser, cucumber salad and apricots or blended juice, chicken pasta salad, whole wheat dinner roll, jellied salad and rice krispie square were to be served. None of these menu items were served for lunch and it was noted that the residents received pineapple juice, ham and salads, dinner roll, peach pie or cannelloni, green beans, and cherries.

The planned menu for the supper meal August 20, 2015, indicated the meal to be served was vegetable cocktail, swiss steak, buttermilk mashed potatoes, seasoned brussel sprouts, peach upside down cake or lamb meatballs, lemon sauce, curried rice, diced beets and seasonal berries. The actual meal served was fish and chips, jello salad, ice cream, or shepherd's pie, mixed vegetable and plums.

The planned lunch menu for August 21, 2015, indicated that broccoli cheddar frittata, peas and mixed salad were to be served, however, an omelet was served with mixed broccoli and cauliflower salad. Mixed greens were the alternate choice of vegetable, however, a pasta salad was served instead. The remainder of the meal was as per the planned menu.

At the supper meal August 21, 2015, pasta salad was served instead of the country cut fries and chocolate cookies were served instead of brownies. The alternate was changed from glazed yams to asparagus and plums were changed to peaches. The remainder of the meal was as per the planned menu.

Two cooks/dietary aides, as well as the Food Service Manager, confirmed the changes to the planned menus.

B. A review of the production sheets and standardized recipes for week four of the spring and summer menu revealed that production sheets were not available to guide staff in preparation of menu items for each meal. The production sheets were predominantly blank but indicated they should include the following: advanced preparation, items to be taken from the freezer, special orders, special instructions, the person who was responsible for the preparation, the recipe code/number, the portion size, how much raw

product was to be prepared, quantities of regular, pureed, minced and modified diabetic portions to be prepared, how many leftovers there were and menu substitutions were to be recorded.

A review of the standardized recipes binder revealed that the recipes were in quantities ranging from 25 - 150 servings and recipes were not available for each of the menu items.

During an interview, on September 4, 2015, the Food Service Manager indicated that generally the cooks prepared an approximate 50/50 split between the two choices that were offered at each meal for the 33 residents in the home. She acknowledged that the cooks would not use recipes in the quantities of 25, 50, 75, 100 and 150 servings as noted on the standardized recipes available. She confirmed that recipes were not available for each of the items on the menu cycle.
The Food Service Manager also acknowledged that the home did not have production sheets available to guide food production for each meal and snack.

C. Despite the numerous changes to the menus observed August 19-21, 2015, there was no evidence to indicate that menu substitutions were documented on the production sheets.

The Food Service Manager acknowledged that menu substitutions were not documented to provide a record of the changes being made to the menus.

D. Menu changes were not communicated to residents on the daily and weekly menus posted outside the dining room nor on the menus attached to the snack cart.

Observation of partial afternoon snack, on an identified date, revealed that the snack cart did not contain all the items on the planned menu. Homo milk, coconut cream cookies, and pureed coconut cream cookies were not provided.

The personal support worker serving the snack cart smelled the pureed food item to see what it was as the changes to the planned menu had not been communicated. She/he indicated that she/he thought that it was a pureed ham sandwich being served to residents on a pureed texture.

The cook who had prepared the snack confirmed during an interview that it was a pureed ham sandwich on the snack cart.

The Food Service Manager acknowledged the expectation was that menu changes should be communicated to residents and staff.

The Administrator/Director of Care indicated the expectation was that the food production system was organized to ensure standardized recipes and production sheets were available for all menu items, menu items were prepared according to the planned menu, menu substitutions were communicated to residents and staff and that the menu substitutions were documented on the production sheet.

The scope of this issue was widespread because all residents were affected by the food production system. The home did not have a history of non-compliance with this regulation. The severity of the issue was determined to be a level two with potential for harm related to staff not being provided the tools required to prepare food, including standardized recipes and production sheets. [s. 72. (2)]

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 O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for routine,

preventative and remedial maintenance.

Observations, during the initial tour and throughout the Resident Quality Inspection, revealed identified deficiencies including:
a) Thirteen ceiling tiles in the lower floor hallway, 32 ceiling tiles in the second floor hallway, and seven ceiling tiles in resident bedrooms were noted to be stained with a brown substance. One ceiling tile in a resident bedroom was cracked.
b) Four ceiling tiles, a plastic ceiling light cover and the metal grid frame were rusted in the lower level. One of the four tiles was visibly wet and a black substance which the Administrator/Director of Care described as mould was evident. She indicated the issue was related to a leaking toilet.
c)Paint scrapes were noted on the lower half of the wall and baseboard heater across from the second floor nursing station.
d) One wall was damaged in the dining/sitting room and four of the painted cupboard doors in the dining area were scraped.
e)The flooring on second floor was lifting across the hallway at the fire doors in the east wing.
f)Damaged and paint chipped doors, door frames, walls and closet doors were observed in 10/16 (62.5 per cent) resident rooms.
g)Baseboards were lifting off walls in 3/16 (18.75 per cent) resident bathrooms and bedrooms.
h)Flooring was broken and missing at the threshold to one bathroom. Two metal brackets mounted on the bathroom wall beside the toilet posed a potential risk to the residents.
i)Bathroom vanities were worn and chipped in 2/16 (12.5 per cent) resident bathrooms.
j)A loose toilet paper holder was noted in one resident bathroom.
k)A large hole under the sink, drywall peeling and large area of broken drywall were observed in 2/16 (18.75 per cent) resident bathrooms.
l)The flooring was stained behind and beside the toilet and the caulking was peeling at the base of the toilet in one resident bathroom.
m)Scrape marks and chipped paint was noted on the Maximove resident lift.
n)The foot board of one bed was damaged and gouged with sharp areas of wood exposed posing a potential risk to the resident.

On September 3, 2015, a tour was conducted with the Administrator/Director of Care who confirmed the identified deficiencies.

A review of the organized program of maintenance services revealed there was no

documented evidence to support that there were schedules and procedures in place for routine, preventative and remedial maintenance.

The Administrator/Director of Care confirmed that a preventative maintenance schedule was not in place and the expectation was that there would be schedules and procedures in place for routine, preventative and remedial maintenance.

The scope of this issue indicated a pattern because 62.5 per cent of resident rooms were not maintained. The home did not have a history of non-compliance with this sub-section of the regulation. The severity of the issue was was determined to be a level two with potential for harm. [s. 90. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and kept inaccessible to residents at all times.

On an identified date, hazardous chemicals were observed under the sink in the activation room as well as on a shelf in the Activation Manager's unlocked and unattended office within the activation room.

The Administrative Assistant confirmed the observations and acknowledged that the hazardous chemicals were accessible to residents.

On an identified date, a resident was observed sitting in the hair salon unattended. A cupboard was unlocked and contained hazardous chemicals.

The Administrator/Director of Care verified the observation and acknowledged that the hazardous chemicals were accessible to the resident and the expectation was that all hazardous chemicals were to be kept inaccessible to residents.

Hazardous chemicals were also observed, by Inspector #128, in the unlocked and unattended hair salon, on another identified date.

The Administrative Assistant confirmed the observations and acknowledged that the hazardous chemicals were accessible to residents. [s. 91.]

2. Hazardous chemicals were observed sitting in a laundry basket on a bench, in the lower level hallway, across from the secure elevator, on an identified date. The basket contained an unlabelled plastic bottle with a clear liquid yellowish substance and two unlabelled specimen bottles which were half full. A 450 millilitre bottle of three per cent Hydrogen Peroxide which expired in October 2001 was observed in the basket along with five other bottles of hazardous chemicals.

The Administrative Assistant confirmed the hazardous chemicals were accessible and unattended. The chemicals were accessible in the area for 12 minutes.

A nurse acknowledged during an interview that the hazardous chemicals should not have been left accessible to residents.

The Administrator/Director of Care indicated the expectation was that hazardous chemicals should never be accessible to residents and that they should be properly labelled.

The scope of this issue was a pattern because the issue was not isolated and did not affect greater than 67 per cent of residents in the home. The home has history of non-compliance with this regulation and a Written Notification and Voluntary Plan of Correction were issued during the August 2014 RQI, Inspection #2014_259520_0023. The severity of the issue was determined to be a level two with potential for harm to residents. [s. 91.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times.

A review of the nursing schedule for a period of 100 days revealed that 63 shifts out of the 300 shifts (21 per cent) were covered by a Registered Practical Nurse and not a Registered Nurse.

The Administrator/Director of Care confirmed that the 63 shifts were not covered by a Registered Nurse.

The scope of this issue was isolated as Registered Staff were not available less than 33 per cent of the time. There was a history of non-compliance with this regulation. It was issued as a Written Notification and a Voluntary Plan of Correction in the August 2014 RQI, Inspection # 2014_259520_0023. The severity was determined to be a level two with the potential to negatively affect the health, safety and well-being of residents in the home. [s. 8. (3)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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 has failed to ensure that the policy, protocol and procedure related to the complaints process was in compliance with and was implemented in accordance with the Act.

A review of the home's policy entitled Obtaining Information and Raising Concerns/Complaints or Recommending Changes, dated July 17, 1995 and reviewed March 2015 revealed there was no documented evidence that the policy had been undated to reflect current legislative requirements, including written procedures for initiating and dealing with complaints.

The Administrator/Director of Care confirmed the policy was not up to date and the expectation was that policies should be written in accordance with the Act. [s. 8. (1) (a)]

2. The licensee has failed to ensure that the policy and procedures related to emergency measures were complied with.

On an identified date, the home had a planned shut off of the power in the building resulting in all exterior doors to be unlocked and the alarms disabled. Inspector #515 observed the second floor east stairwell leading to the outside to be unlocked and

unattended and no staff were visible in the east hallway. A resident was in the hallway in a wheelchair and other residents were present in their rooms.
A registered nurse confirmed the exit door was unlocked and unattended and the expectation was that staff in the home should have monitored the door leading to the outside.

A tour of the second floor by Inspectors #128 and #515 revealed that three residents were not accounted for. The charge nurse acknowledged that she was initially unsure of the whereabouts of the three residents. Upon further inspection of the building, it was determined that two of the residents were on the lower level and one resident was not in the building.

A review of the policy entitled Emergency Measure - Generator, Section L - page 4, dated January 7, 2008, indicated that it was expected that staff would be dispersed to cover the exit doors of the nursing care level. The policy also indicated that the charge nurse was to keep track of all residents' whereabouts and account for all comings and goings.

The Administrator/Director of Care indicated that the planned power shut off should not have occurred on a day when she was not in the building. She acknowledged that the emergency measure policy was not complied with when exit doors were not monitored and the charge nurse was not aware of the whereabouts of all residents. [s. 8. (1) (b)]

3. The licensee has failed to ensure that the policy and procedures related to falls interventions were complied with.

A review of the home's policy entitled Fall Interventions Risk Management (FIRM) Program - Implementation, Index: LTC-N-75, dated February 2008, revealed that "if a fall is not witnessed or the resident hit his/her head, the head injury routine will be initiated using the Neurological Flow Sheet".

A clinical record review for resident #010 revealed that during an eight month period, the resident had seven documented unwitnessed falls.
There was no documented evidence to support that head injury routine using the neurological flow sheet was initiated for any of the falls.

A registered staff member and the Administrator/Director of Care confirmed in an interview that the falls were not witnessed and that the head injury routine should have

been initiated as per the procedure for post fall management.

The Administrator/Director of Care confirmed in an interview that the home's expectation was that the post fall management policy should be complied with by the staff. (523) [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 policies related to complaints are developed and implemented in accordance with the Long-Term Care Homes Act and Regulation and to ensure that all implemented policies related to falls prevention and emergency procedures are complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to the outside of the home were kept closed and locked and equipped with a door access control system that was kept on at all times.

On an identified date the west exterior door in the second floor dining/sitting room which led to a metal platform and stairs to the ground was observed unlocked and the door alarm was turned off. There were three residents seated in wheelchairs in the room which was unattended.

A registered nurse confirmed that the door had been unlocked to let a bat out of the building and the door was not locked and the alarm was not re-set after the incident.

The Administrator/Director of Care confirmed the expectation that all doors leading to the outside of the home were to be kept closed and locked with the alarm on at all times. [s. 9. (1) 1.]

2. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

The mechanical room which contained electrical panels, hot water heater, water softener, sprinkler system valves and cistern was observed open and unattended, on an identified date. This room was on the lower level and was accessible to residents through the secure elevator and/or at times when they were on the lower level in an activity.

The Administrator/Director of Care confirmed the door was unlocked and unsupervised and that the expectation was that residents should not have access to non-resident areas.

The mechanical room was found unlocked and unattended again, on an identified date. The maintenance worker confirmed the room was open and unattended. No residents were in the area at the time.

On another identified date, the mechanical room was observed open and unattended with the key in the door. A resident was in the lower activity room watching television. The resident left the area at seven minutes later. The room remained open and unattended for 13 minutes when a staff member returned and confirmed that the room was unlocked and unsupervised. She/he closed the door and left the area but left the key in the door. The key was removed from the door 24 minutes after the staff member returned to the area.

The Administrator/Director of Care indicated, after each incident, that the expectation was that the door to the mechanical room was to be closed and locked when the room was not being supervised. [s. 9. (1) 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 all doors leading to the outside of the home are kept closed and locked and equipped with a door access control system that is kept on at all times and that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Observations, during the initial tour and throughout the Resident Quality Inspection, revealed identified housekeeping deficiencies, including:
a)Dirty nail clippings were observed in the tub room nail clipper storage cabinet bottom drawer.
b)Black dirt/debris, floor stains observed around the base of toilets and thresholds between bathroom/bedroom in 6/16 (37.5 per cent) of resident rooms.
c)Dust was visible in ceiling vents in the utility room and a floor fan in one resident bathroom/bedroom.
d)Dead insects were visible in 10/16 (62.5 per cent) of the light fixtures on the second floor and 3/16 (18.75 per cent) of resident bathrooms/bedrooms.
e)A commode had a build-up of debris and dirt on the legs and wheels.
f)The Maximove lift had dust and spills on the base of the resident lift.
g)A comfortable chair was soiled with white debris on both arms.

On September 3, 2015, a tour was conducted with the Administrator/Director of Care who confirmed the identified deficiencies.

The Administrator confirmed the expectation was that the home, furnishings and equipment were kept clean and sanitary. [s. 15. (2) (a)]

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 home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practises and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to minimize risk to the resident.

On an identified date, a half bed rail was observed inserted between the top and bottom mattresses on the right side of the bed for Resident #012. It was positioned mid-way between the headboard and footboard. The bed rail was not secured to the bed frame and could be pushed or pulled out, enabling the rail to slip away from the mattress.

The Administrator/Director of Care confirmed the observation, acknowledged that the bed rail did not belong to the home and was unaware that the bed rail was being used on the resident's bed. The bed system was exchanged for a different bed system that day.

The Administrator/Director of Care further confirmed that a resident assessment had not been completed and the bed system was not evaluated and the expectation was that where bed rails were used, the resident was assessed and the bed system evaluated. (515) [s. 15. (1)]

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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to minimize risk to the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints that were received concerning the care of a resident or the operation of the home were immediately forwarded to the Director.

A review of the Complaints Log, for an identified date, revealed a staff documented concerns regarding care provision of a resident by a staff member.

In an interview, the Administrator/Director of Care confirmed that the staff member was interviewed and disciplined as a result of the internal investigation, but a Critical Incident report was not submitted to the Director.

Following discovery of the documented incident and questioning of the Administrator/Director of Care, a report was submitted to the Ministry. [s. 22. (1)]

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 written complaints that are received concerning the care of a resident or the operation of the home are immediately forwarded to the Director, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the annual evaluation of the Falls Prevention Program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

An interview with Administrator/Director of Care, on September 2, 2015, revealed that there was no written record of the annual evaluation of the Falls Prevention Program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the Falls Prevention Program with the Administrator/Director of Care revealed that the program was last updated in February 2014.

The Administrator/Director of Care confirmed that there was no written record of the evaluation and that the expectation would be to evaluate the program annually and to keep a written record that included all the required components, as well as the date that those changes were implemented. [s. 30. (1) 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 a written record is kept of the annual evaluation of each organized program that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the staffing plan binder revealed that there was no written record of each annual evaluation of the staffing plan.

On September 4, 2015, during an interview, the Administrator/Director of Care confirmed that there was no written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. She confirmed that the expectation was that a written record of each annual evaluation of the staffing plan should be kept. [s. 31. (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 a written record is kept of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participate in the evaluation, a summary of the changes made and the date that those changes are implemented, to be implemented voluntarily.

WN #13: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were utilized to assist residents with eating, including safe positioning of residents who required assistance.

A personal support worker was observed standing to assist resident #011, with drinking a beverage, at afternoon snack, on an identified date. The resident was not in a safe eating position while lying in bed at an approximate 120 degree angle. The personal support worker was standing approximately 18 inches above the eye level of the resident. The resident started to cough while being assisted with the beverage.

The personal support worker acknowledged that the resident was not in a safe feeding position and that the resident should have been in an upright position and he/she should have been seated to assist the resident. The personal support worker also acknowledged that staff needed to be careful while assisting the resident with eating because the resident was at risk for choking.

The Administrator acknowledged the potential risk and indicated the expectation was that staff were to be at the resident's eye level to ensure safe feeding. She confirmed the resident was at choking risk and indicated that the resident should have been repositioned in bed prior to being assisted with eating/drinking. [s. 73. (1) 10.]

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 proper techniques are utilized to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #14: 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 stored in a medication cart were secure and locked.

An unlocked and unattended medication cart was observed sitting in the hallway, near the nursing station, on an identified date. The cart was unattended for two minutes before the registered nursing staff member returned to the area.

The registered nursing staff member confirmed that the cart was unattended and not locked.

The Administrator/Director of Care acknowledged the expectation was that drugs were to be secured in the medication cart and that the medication cart should have been locked when not attended. [s. 129. (1) (a) (ii)]

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 a medication cart that is secure and locked, to be implemented voluntarily.

WN #15: 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. 6 (7) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

On an identified date, resident #006 was observed lying in bed without the call bell within reach. The call bell was noted to be behind the bed.

Two personal support workers confirmed the call bell was behind the bed and not within reach of the resident. They indicated that the call bell should have been in reach for this resident.

A clinical record review revealed that the plan of care indicated that resident #006 was to have the call bell easily accessible when in bed related to being at risk for falls.

The Administrator/Director of Care acknowledged that the call bell should have been within reach of the resident as specified in the plan of care. [s. 6. (7)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information, specifically, copies of the inspection reports from the past two years for the long-term care home, were posted in the home, in a conspicuous and easily accessible location.

On August 29, 2015, during the initial tour of the home, it was observed that there was no evidence to support that copies of the inspection reports from January 2014, March 2014 and August 2014, were posted in the home.

The Administrator/Director of Care acknowledged that the reports were not posted and indicated that she was unaware of the requirement to post the inspection reports for the past two years. She confirmed the expectation was that the home would post the required information in the home in accordance with the legislation. [s. 79. (3) (k)]

Issued on this 13th day of October, 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) :	RUTH HILDEBRAND (128), ALI NASSER (523), RAE MARTIN (515)
Inspection No. / No de l'inspection :	2015_182128_0020
Log No. / Registre no:	019816-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 2, 2015
Licensee / Titulaire de permis :	ATK CARE INC. 1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6
LTC Home / Foyer de SLD :	THE FORDWICH VILLAGE NURSING HOME 3063 Adelaide Street, Fordwich, ON, N0G-1V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SUSAN JAUNEZMIS

To ATK CARE 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Order / Ordre :

The licensee must develop a process to ensure that there are written procedures developed that outline how complaints lodged with the licensee will have a documented record kept.
The documented record must include:
- the nature of each verbal or written complaint;
- the date the complaint was received;
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- the final resolution, if any;
- every date on which any response was provided to the complainant and a description of the response; and
- any response made in turn by the complainant.

This process must be implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A review of written communication from a resident's family member to the Administrator/Director of Care revealed the family member submitted a written concern regarding identified care issues.

On September 2, 2015, a review of the home's complaint logs entitled Resident/Family/Staff Concern Forms revealed there was no evidence that the following was documented for concerns identified on four of four complaints (100 per cent):
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- the final resolution, if any;
- every date on which any response was provided to the complainant and a description of the response; and
- any response made in turn by the complainant.
The complaints had four identified dates.

In an interview, the Administrator/Director of Care acknowledged that the complaint logs did not contain the required information in accordance with the legislation and confirmed the expectation that the documented record in the home should include all the required information.

The scope of this issue was widespread because 100 per cent of written complaints reviewed did not have written records containing all the required information. The home did not have a history of non-compliance with this regulation. The severity of the issue was determined to be a level two with potential for harm. (515)

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

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure that an organized system of food production is in place to guide preparation of meals and snacks for residents.

The plan must identify how the home will develop a food production system to ensure that menu items are prepared according to the planned menu. Please also identify who will be responsible for monitoring that planned menus are followed.

The food production system must include development of production sheets and standardized recipes for each of the menu items on the planned meal and snack menus.
Please identify who will be responsible for developing the production sheets and the standardized recipes and ensuring that menu substitutions are documented on the production sheets, as well as who will monitor that they are available and utilized on an ongoing basis.

The plan must also identify that dietary and nursing staff have received education related to ensuring planned menus are followed and that substitutions are communicated to residents and staff. Please identify who will be responsible for providing this education.

This plan must also identify time frames when each of the components will be achieved.

Please submit the written plan to Ruth Hildebrand, Long-Term Care Homes Inspector - Dietary, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2, via email to ruth.hildebrand @ ontario.ca by October 23, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized food production system that, at a minimum, provided for the following:
-standardized recipes and production sheets for all menus;
-preparation of all menu items according to the planned menu;
-communication to residents and staff of any menu substitutions; and
-documentation on the production sheet of any menu substitutions.

A. Observation of the lunch meal, on August 19, 2015, revealed that the planned

menu for week four of the spring and summer menu had been changed. The week at a glance menu indicated the planned lunch meal was minestrone soup, ham salad plate, and citrus fruit cup or grape juice, crunchy perch, sweet potato fries, creamy coleslaw, and chocolate mousse. However, the actual meal served was grape juice, sandwich plate, chocolate mousse or quiche, peas, and applesauce.

The planned supper meal for August 19, 2015, indicated it was to be a residents' choice meal whereby the residents decided what was to be served. Nothing was identified on the week at a glance menu regarding the choice that the residents had made. The meal served was cabbage rolls, corn on the cob and strawberry bars.

The planned menu for lunch August 20, 2015, indicated that cream of mushroom soup, sliced pork with cajun mayonnaise on a kaiser, cucumber salad and apricots or blended juice, chicken pasta salad, whole wheat dinner roll, jellied salad and rice krispie square were to be served. None of these menu items were served for lunch and it was noted that the residents received pineapple juice, ham and salads, dinner roll, peach pie or cannelloni, green beans, and cherries.

The planned menu for the supper meal August 20, 2015, indicated the meal to be served was vegetable cocktail, swiss steak, buttermilk mashed potatoes, seasoned brussel sprouts, peach upside down cake or lamb meatballs, lemon sauce, curried rice, diced beets and seasonal berries. The actual meal served was fish and chips, jello salad, ice cream, or shepherd's pie, mixed vegetable and plums.

The planned lunch menu for August 21, 2015, indicated that broccoli cheddar frittata, peas and mixed salad were to be served, however, an omelet was served with mixed broccoli and cauliflower salad. Mixed greens were the alternate choice of vegetable, however, a pasta salad was served instead. The remainder of the meal was as per the planned menu.

At the supper meal August 21, 2015, pasta salad was served instead of the country cut fries and chocolate cookies were served instead of brownies. The alternate was changed from glazed yams to asparagus and plums were changed to peaches. The remainder of the meal was as per the planned menu.

Two cooks/dietary aides, as well as the Food Service Manager, confirmed the changes to the planned menus.

B. A review of the production sheets and standardized recipes for week four of the spring and summer menu revealed that production sheets were not available to guide staff in preparation of menu items for each meal. The production sheets were predominantly blank but indicated they should include the following: advanced preparation, items to be taken from the freezer, special orders, special instructions, the person who was responsible for the preparation, the recipe code/number, the portion size, how much raw product was to be prepared, quantities of regular, pureed, minced and modified diabetic portions to be prepared, how many leftovers there were and menu substitutions were to be recorded.

A review of the standardized recipes binder revealed that the recipes were in quantities ranging from 25 - 150 servings and recipes were not available for each of the menu items.

During an interview, on September 4, 2015, the Food Service Manager indicated that generally the cooks prepared an approximate 50/50 split between the two choices that were offered at each meal for the 33 residents in the home. She acknowledged that the cooks would not use recipes in the quantities of 25, 50, 75, 100 and 150 servings as noted on the standardized recipes available. She confirmed that recipes were not available for each of the items on the menu cycle.
The Food Service Manager also acknowledged that the home did not have production sheets available to guide food production for each meal and snack.

C. Despite the numerous changes to the menus observed August 19-21, 2015, there was no evidence to indicate that menu substitutions were documented on the production sheets.

The Food Service Manager acknowledged that menu substitutions were not documented to provide a record of the changes being made to the menus.

D. Menu changes were not communicated to residents on the daily and weekly

menus posted outside the dining room nor on the menus attached to the snack cart.

Observation of partial afternoon snack, on an identified date, revealed that the snack cart did not contain all the items on the planned menu. Homo milk, coconut cream cookies, and pureed coconut cream cookies were not provided.

The personal support worker serving the snack cart smelled the pureed food item to see what it was as the changes to the planned menu had not been communicated. She/he indicated that she/he thought that it was a pureed ham sandwich being served to residents on a pureed texture.

The cook who had prepared the snack confirmed during an interview that it was a pureed ham sandwich on the snack cart.

The Food Service Manager acknowledged the expectation was that menu changes should be communicated to residents and staff.

The Administrator/Director of Care indicated the expectation was that the food production system was organized to ensure standardized recipes and production sheets were available for all menu items, menu items were prepared according to the planned menu, menu substitutions were communicated to residents and staff and that the menu substitutions were documented on the production sheet.

The scope of this issue was widespread because all residents were affected by the food production system. The home did not have a history of non-compliance with this regulation. The severity of the issue was determined to be a level two with potential for harm related to staff not being provided the tools required to prepare food, including standardized recipes and production sheets. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan to demonstrate how further development of the organized maintenance services will ensure that there are preventative maintenance schedules and procedures in place to guide staff.

Please indicate what procedures will be developed to ensure the home is maintained and indicate who will be responsible for developing the schedules and procedures for routine, preventive and remedial maintenance, as well as who will be responsible for ensuring the schedules and procedures are utilized on an ongoing basis.

This plan must also identify time frames when each of the components will be achieved.

Please submit the written plan to Ruth Hildebrand, Long-Term Care Homes Inspector - Dietary, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2, via email to ruth.hildebrand @ ontario.ca by October 23, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for

routine, preventative and remedial maintenance.

Observations, during the initial tour and throughout the Resident Quality Inspection, revealed identified deficiencies including:
a) Thirteen ceiling tiles in the lower floor hallway, 32 ceiling tiles in the second floor hallway, and seven ceiling tiles in resident bedrooms were noted to be stained with a brown substance. One ceiling tile in a resident bedroom was cracked.
b) Four ceiling tiles, a plastic ceiling light cover and the metal grid frame were rusted in the lower level. One of the four tiles was visibly wet and a black substance which the Administrator/Director of Care described as mould was evident. She indicated the issue was related to a leaking toilet.
c)Paint scrapes were noted on the lower half of the wall and baseboard heater across from the second floor nursing station.
d) One wall was damaged in the dining/sitting room and four of the painted cupboard doors in the dining area were scraped.
e)The flooring on second floor was lifting across the hallway at the fire doors in the east wing.
f)Damaged and paint chipped doors, door frames, walls and closet doors were observed in 10/16 (62.5 per cent) resident rooms.
g)Baseboards were lifting off walls in 3/16 (18.75 per cent) resident bathrooms and bedrooms.
h)Flooring was broken and missing at the threshold to one bathroom. Two metal brackets mounted on the bathroom wall beside the toilet posed a potential risk to the residents.
i)Bathroom vanities were worn and chipped in 2/16 (12.5 per cent) resident bathrooms.
j)A loose toilet paper holder was noted in one resident bathroom.
k)A large hole under the sink, drywall peeling and large area of broken drywall were observed in 2/16 (18.75 per cent) resident bathrooms.
l)The flooring was stained behind and beside the toilet and the caulking was peeling at the base of the toilet in one resident bathroom.
m)Scrape marks and chipped paint was noted on the Maximove resident lift.
n)The foot board of one bed was damaged and gouged with sharp areas of wood exposed posing a potential risk to the resident.

On September 3, 2015, a tour was conducted with the Administrator/Director of Care who confirmed the identified deficiencies.

A review of the organized program of maintenance services revealed there was no documented evidence to support that there were schedules and procedures in place for routine, preventative and remedial maintenance.

The Administrator/Director of Care confirmed that a preventative maintenance schedule was not in place and the expectation was that there would be schedules and procedures in place for routine, preventative and remedial maintenance.

The scope of this issue indicated a pattern because 62.5 per cent of resident rooms were not maintained. The home did not have a history of non-compliance with this sub-section of the regulation. The severity of the issue was determined to be a level two with potential for safety and harm to residents. (515)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Order / Ordre :

The licensee must ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.
The licensee must also provide education to all staff and service providers to ensure that they are aware that hazardous substances are to be labelled properly and are to kept inaccessible to residents at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and kept inaccessible to residents at all times.

On an identified date, hazardous chemicals were observed under the sink in the activation room as well as on a shelf in the Activation Manager's unlocked and unattended office within the activation room.

The Administrative Assistant confirmed the observations and acknowledged that the hazardous chemicals were accessible to residents.

On an identified date, a resident was observed sitting in the hair salon unattended. A cupboard was unlocked and contained hazardous chemicals.

The Administrator/Director of Care verified the observation and acknowledged that the hazardous chemicals were accessible to the resident and the expectation was that all hazardous chemicals were to be kept inaccessible to residents.

Hazardous chemicals were also observed, by Inspector #128, in the unlocked and unattended hair salon, on another identified date.

The Administrative Assistant confirmed the observations and acknowledged that the hazardous chemicals were accessible to residents.
(515)

2. Hazardous chemicals were observed sitting in a laundry basket on a bench, in the lower level hallway, across from the secure elevator, on an identified date. The basket contained an unlabelled plastic bottle with a clear liquid yellowish substance and two unlabelled specimen bottles which were half full. A 450 millilitre bottle of three per cent Hydrogen Peroxide which expired in October 2001 was observed in the basket along with five other bottles of hazardous chemicals.

The Administrative Assistant confirmed the hazardous chemicals were accessible and unattended. The chemicals were accessible in the area for 12 minutes.

A nurse acknowledged during an interview that the hazardous chemicals should not have been left accessible to residents.

The Administrator/Director of Care indicated the expectation was that hazardous chemicals should never be accessible to residents and that they should be properly labelled.

The scope of this issue was a pattern because the issue was not isolated and did not affect greater than 67 per cent of residents in the home. The home has history of non-compliance with this regulation and a Written Notification and Voluntary Plan of Correction were issued during the August 2014 RQI, Inspection #2014_259520_0023. The severity of the issue was determined to be a level two with potential for harm to residents.
(128)

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must continue recruitment efforts to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times.

A review of the nursing schedule for a period of 100 days revealed that 63 shifts out of the 300 shifts (21 per cent) were covered by a Registered Practical Nurse and not a Registered Nurse.

The Administrator/Director of Care confirmed that the 63 shifts were not covered by a Registered Nurse.

The scope of this issue was isolated as Registered Staff were not available less than 33 per cent of the time. There was a history of non-compliance with this regulation. It was issued as a Written Notification and a Voluntary Plan of Correction in the August 2014 RQI, Inspection # 2014_259520_0023. The severity was determined to be a level two with the potential to negatively affect the health, safety and well-being of residents in the home. (523)

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

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
Fax: 416-327-7603

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

Issued on this 2nd day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUTH HILDEBRAND

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