Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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
Feb 10, 2015	2014_380593_0019	S-000536-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE CITY OF TIMMINS
481 Melrose Blvd. TIMMINS ON P4N 5H3

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

GOLDEN MANOR
481 MELROSE BOULEVARD TIMMINS ON P4N 5H3

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

GILLIAN CHAMBERLIN (593), LAUREN TENHUNEN (196), SYLVIE LAVICTOIRE (603), TIFFANY BOUCHER (543)

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): December 09th - 12th, 15th - 19th, 2014

In addition, seven additional logs were incorporated into the RQI which included seven reported Critical Incidents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager, Registered Nursing Staff, Registered Dietitian (RD), Dietary Staff, Activation Staff, Maintenance Staff, Personal Support Workers (PSW), residents and family members.

The inspector(s) also observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

10 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

s. 75. (4) For the purposes of subsection (3), but subject to subsection (5), the minimum number of hours per week shall be calculated as follows: M = A × 8 ÷ 25 where, "M" is the minimum number of hours per week, and "A" is,
(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or O. Reg. 79/10, s. 75 (4).
(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents. O. Reg. 79/10, s. 75 (4).

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

During an interview with Inspector #593 December 17, 2014, the home's Registered Dietitian (RD) / Nutrition Supervisor advised that along with being the designated RD for the home, they are also the designated lead of the food services program. They further added that their duties and hours as Registered Dietitian come first and after this role is fulfilled, they complete their hours as Nutrition Supervisor. The RD / Nutrition Supervisor advised that they took on the additional role of Nutrition Supervisor when the previous Nutrition Supervisor left on long-term disability leave. The home did not advertise for this position as the cost savings were re-allocated within the home towards infection prevention and control. As far as they are aware, they will be both the home's RD and Nutrition Supervisor going forward and are aware that they do not meet the hours in the regulations to carry out the duties as both RD and Nutrition Supervisor.

During an interview with Inspector #593 December 18, 2014, the Administrator advised that along with the home's RD, the Housekeeping Supervisor is also qualified to lead the nutrition department and assist as required. The Administrator believed that because they have two staff members qualified to lead this program, they are meeting the required hours as outlined in the regulations however pursuant to O. Reg. 79/10, s. 75 (3) hours on-site cannot be spent fulfilling other responsibilities.

The home has occupancy for 177 residents and at the time of the inspection the occupancy of the home was above 97 percent. Pursuant to O. Reg. 79/10, s. 75 (4) the minimum hours a nutrition manager is required to be on site at the home working in the capacity of nutrition manager is full-time hours. As such, the licensee has failed to ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including an hours spent fulfilling other responsibilities. [s. 75. (3)]

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

On December 9, 2014, during the evening meal in one of the home's dining rooms Inspector #593 found residents being served either a regular textured or a pureed textured meal. Staff member #102 advised that they were not serving minced textured meals as there were no residents in this unit who required a minced textured diet. They also added that there is a list in the servery which displays, at a glance, the meal texture for each resident as well as the residents requiring thickened fluids. Staff member #104 also advised at a later meal service that there were no residents in this unit that required a minced textured diet.

A review of the menu cards located in the servery found that Residents #022 and #023 were required to have a minced textured diet. A review of Resident #022's health care record found a physician's order for a minced textured diet however they were observed by Inspector #593 to be served a pureed textured meal. A review of Resident #023's health care record found a physician's order for a pureed textured diet. This was inconsistent with the texture documented on the menu cards in the dining room's servery December 9, 2014.

Inspector #593 observed a staff member feeding a meal and thickened fluid to Resident #024 in their room. When questioned about the thickened fluids, the staff member advised that they believed the resident was to have honey thickened fluids. Inspector #593 observed no thickened fluid listed for this resident on the list located in the servery. A review of Resident #024's health care record found a physician's order for nectar thick fluids. Furthermore, during additional observations of the dining area, Inspector #593 noted that the menu card for this resident had been updated to include the thickened fluids however the consistency documented was pudding thick which is inconsistent with

both the physician's orders and the fluids being provided to the resident.

A review of the menu cards located in another unit in the home found that Resident #025 was required to have a minced textured diet. A review of Resident #025's care plan found that the resident was to be provided a regular diet. This was inconsistent with the menu card for this resident located in the servery of the unit.

A review of the menu cards located in the same unit found that Resident #026 was required to have a pureed textured diet. A review of Resident #026's care plan found that the resident was to be provided a minced diet. This was inconsistent with the menu card for this resident located in the servery of the unit.

During an interview with Inspector #593 December 17, 2014, staff member #105 advised that there were no residents in a particular unit of the home that required thickened fluids however there were two residents, Residents #027 and #028 who experienced day to day changes in their swallowing and sometimes required thickened fluids. For this reason, a small amount of thickened fluids was prepared to have available should it be required. A review of Resident's #027 and #028 plan of care found no documentation of either residents swallowing difficulties or the occasional requirement for thickened fluids.

During an interview with Inspector #593 December 17, 2014, the RD / Nutrition Supervisor advised that the information on the menu cards should be consistent with the physician's orders. They further added that the menu cards are an ongoing problem in the home as it is difficult to keep them accurately updated.

As such, the licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. This non-compliance is supported by the following findings:

A Critical Incident was submitted by the home regarding an incident, where a resident choked as a result of a piece of food becoming lodged in their throat.

During an interview with Inspector #593 December 18, 2014, the RD / Nutrition Supervisor advised that Resident #013 was on a pureed diet as they were refusing to wear their dentures and therefore had difficulty with chewing. The resident's intake was being affected as the resident did not like the pureed meals so the resident's POA provided permission for the resident to have finger foods. The RD / Nutrition Supervisor

advised that the resident was able to work away at the finger foods without their dentures until they were able to swallow. They added that they are currently working on a list for staff of soft and safe finger foods for residents with swallowing difficulties however this was not yet available.

During an interview with Inspector #593 December 19, 2014, the RD / Nutrition Supervisor advised that they were unsure if the resident actually had a swallowing issue and that the problem was more related to the resident not wearing their dentures during meals. They further added that the resident did have some swallowing difficulties due to disease progression however the resident was ordered a pureed diet as the resident would only accept a pureed diet when being fed by staff in the home. When advised that this information could not be located in the resident's plan of care, they responded that this information was not documented anywhere else in the resident's health care record.

A review of Resident #013's plan of care found that the resident requires assistance for eating related to poor dentition, is to be provided a pureed diet however can have finger foods when available. A review of the resident's most recent nutrition assessment indicated that the resident had dysphagia. There was no mention however of the resident choosing not to wear their dentures, subsequent chewing problems as a result of the resident not wearing their dentures during meal times nor instructions of how the resident safely eats or the effort required by the resident to safely eat the finger foods provided.

As such, the licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 ensuring that all resident plans of care encompass all aspects of a residents care needs and includes clear directions to all staff involved with direct resident care, to be implemented voluntarily.

WN #3: 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. This non-compliance is supported by the following findings:

During an interview with Inspector #593 December 9, 2014, staff member #102 advised that there was a list in the servery which displays, at a glance, the meal texture for each resident as well as the residents requiring thickened fluids.

Inspector #593 observed a staff member feeding a meal and thickened fluid to Resident #024 in their room.When questioned regarding the thickened fluids, the staff member advised that they believed the resident was to have honey thickened fluids. Inspector #593 observed no thickened fluid listed for this resident on the list located in the servery. A review of Resident #024's health care record found a physician's order for nectar thick fluids. Furthermore, during additional observations of the dining area, Inspector #593 noted that the menu card for this resident had been updated to include the thickened fluids however the consistency documented was pudding thick which is inconsistent with both the physician's orders and fluids being provided to the resident.

During an interview with Inspector #593 December 18, 2014, staff member #104 advised that there were no written instructions available for preparing thickened fluids. They further added that they prepare the thickened fluids using approximate values to measure including resident drinking cups as measuring cups for the powdered thickener.

During an interview with Inspector #593 December 17, 2014, the RD / Nutrition Supervisor advised that the information on the menu cards should be consistent with the physician's orders. They further added that the menu cards are an ongoing problem as it is difficult to keep them accurately updated.

A review of the home's Dietary Services Policy DTS C-26: Thickened Fluids, found that the home is to provide thickened fluids as prescribed by the attending Physician or RD and unless otherwise specified the resident is to receive honey consistency fluids when

posted as thickened fluids. The policy includes instructions for preparing thickened fluids however instructions are available for only one consistency of thickened fluids which is honey.

During an interview with Inspector #593 December 18, 2014, the RD / Nutrition Supervisor advised that directions for preparing thickened fluids can be located in the servery of each unit. Furthermore, staff should be following these directions when preparing thickened fluids. The RD / Nutrition Supervisor added that they are working to review the home's Thickened Fluid policy as the current standard in the home is that residents are started on honey thickened fluids until they are assessed by an RD or Speech Pathologist and an alternative is advised if required.

As such, the licensee has failed to ensure that residents are provided with food and fluids that are safe. [s. 11. (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 ensuring that appropriate directions for preparing thickened fluids are available for all staff and that staff providing nourishment to residents are provided education on the safe preparation of thickened fluids. Furthermore, a process should be implemented to ensure that all staff providing nourishment or direct care to a resident are aware of residents fluid requirements and that this information is consistent and easily accessible within the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

Inspector #593 observed December 9, 2014, during the evening meal service in one of the home's dining rooms, a meal of pureed macaroni, beef and peas being served to residents requiring a pureed diet. This was the only meal option available to residents requiring a pureed diet as observed by Inspector #593 and confirmed by staff member #102.

Inspector #593 observed December 9, 2014, during the lunch meal service in another dining area of the home, a meal of minced ham, potato and beets being served to residents requiring a minced diet and a meal of pureed ham, potato and beets being served to residents requiring a pureed diet. This was the only meal option available to residents requiring a pureed diet as observed by Inspector #593 and confirmed by staff member #103.

Inspector #593 observed December 18, 2014 during the lunch meal service in a third dining room in the home, a meal of pureed beef, potatoes and salad being served to residents requiring a pureed diet. This was the only meal option available to residents requiring a pureed diet as observed by Inspector #593 and confirmed by staff member #104.

A review of the home's Dietary Services Policy DTS C-05-40 found that the home's policy is that an alternate choice for each menu entrée shall be available for all diet textures.

During an interview with Inspector #593 December 18, 2014, the home's RD / Nutrition Supervisor advised that all residents are required to have two choices of the main meal; they further added that two main meal options for each texture type should be available at every meal occasion.

As such, the home has failed to provide alternative choices of entrées to residents requiring a texture modified diet at lunch and dinner as required in the regulations. [s. 71. (1) (c)]

2. This non-compliance is supported by the following findings:

Inspector #593 observed December 18, 2014, staff member #100 passing out beverages to residents in one of the units as part of the morning nourishment pass. It was observed that water was being offered to residents and no other choices were observed to be available. During an interview with Inspector #593, December 18, 2014, staff member #100 advised that they only provided water for residents during the morning nourishment pass, nutritional supplements were provided however they were only for residents who had missed breakfast.

Inspector #593 observed December 19, 2014, staff member #101 passing out beverages to residents in another unit of the home as part of the morning nourishment pass. It was observed that water was being offered to residents, no other choices were observed to be available. During an interview with Inspector #593, December 19, 2014, staff member #101 advised that residents will only receive water during the morning nourishment pass and that occasionally residents requiring thickened fluids will receive a thickened juice however most of the time they only receive thickened water.

During an interview with Inspector #593, the home's RD / Nutrition Supervisor confirmed that the morning nourishment pass is a fluid pass of water at 10am. No other beverage options are available at this time.

As such, the licensee has failed to ensure that the home's menu cycle includes alternative beverage choices at snacks. [s. 71. (1) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all residents receiving pureed, minced and regular textured diets are offered alternative choices of entrees at every lunch and dinner service in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The Critical Incident Report #M530-000011-14 and a formal discipline letter staff member #106, identified that the licensee had given a five day suspension, directed the staff member to view a resident handling video, and was required to review the Resident Handling Program upon their return to work. Inspector #603 interviewed staff member #106 and they advised that they did not view a resident handling video or the Resident Handling Program upon their return. Inspector #603 interviewed the Director of Care (DOC) and they agreed that they did not follow through on the discipline and the staff member did not view the video nor review the program. [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the residents' activity patterns and pursuits.

Inspector #603 reviewed Resident #018's plan of care and found no mention of an activation care plan. Staff members, #107 and #108, both activity coordinators confirmed there was no activation care plan. [s. 26. (3) 16.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. Resident #009 was identified by staff member #100 and staff member #109 as requiring rinsing of dentures and cleaning of the mouth after meals. According to staff member #110, residents in the home may be offered a dental assessment if problems arise or if the resident has their own teeth.

An interview was conducted with the DOC December 18, 2014, and it was confirmed that residents are not offered an annual dental assessment and reported to the inspector that going forward all residents will be offered an annual dental assessment at the time of the resident annual care conference.

The licensee has failed to ensure that each resident of the home receives an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

A review of Resident #013's health care records found a decrease of 7.5 percent of the resident's body weight over a three month period. This was identified in the home's electronic records as a significant weight change.

A review of the home's Monitoring Weights Policy NRC E-25 found that resident weights will be monitored to prevent nutritional deficits in accordance with the Long-Term Care Homes Act 2007. Furthermore, residents are to be assessed for any of the following weight changes using an interdisciplinary approach: a) a change of 5% body weight or more, over one month, b) a change of 7.5% of body weight, or more over three months and c) a change of 10% of body weight, or more over six months. The weight loss is to be documented in the resident electronic interdisciplinary progress notes with an explanation or rationale for the weight variance.

During an interview with Inspector #593 December 19, 2014, the home's RD advised that residents who are identified as having weight loss would be referred to the home's RD via registered staff in the home. They are required to complete a diet requisition or change form for referral to the RD. The RD would then complete a nutrition assessment of the resident and an electronic progress note would be completed.

A review of Resident #013's health care record found no nutrition assessment completed by the home's RD after the weight loss of 7.5%. The records show that a nutrition assessment was not undertaken for this resident until seven months after the weight loss was first identified for this resident.

As such, the licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions and outcomes are evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. Inspector #543 spoke with the liaison for the Family Council who confirmed that the licensee did not share the results of the satisfaction survey with the Family Council. The Inspector also spoke with the Resident Services Supervisor who also confirmed that the licensee did not share the results of the satisfaction survey and that it was an oversight on their part, as the Family Council was not established until April 2014. They also stated that they will share the results at the next meeting.

As such, the licensee failed to make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. [s. 85. (4) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

Issued on this 12th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593), LAUREN TENHUNEN (196), SYLVIE LAVICTOIRE (603), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2014_380593_0019
Log No. / Registre no:	S-000536-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 10, 2015
Licensee / Titulaire de permis :	CORPORATION OF THE CITY OF TIMMINS 481 Melrose Blvd., TIMMINS, ON, P4N-5H3
LTC Home / Foyer de SLD :	GOLDEN MANOR 481 MELROSE BOULEVARD, TIMMINS, ON, P4N-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HEATHER BOZZER

To CORPORATION OF THE CITY OF TIMMINS, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Order / Ordre :

The licensee is to ensure that the designated lead of the food services program is on site at the home working in the capacity of nutrition supervisor for the minimum number of hours per week calculated under subsection (4) without including any hours spent fulfilling other responsibilities. The home has 177 beds and as calculated under subsection (4), the nutrition supervisor is required to be on site at the home working full time hours solely as the nutrition supervisor of the home.

Grounds / Motifs :

1. This non-compliance is supported by the following findings:

During an interview with Inspector #593 December 17, 2014, the home's Registered Dietitian (RD) / Nutrition Supervisor advised that along with being the designated RD for the home, they are also the designated lead of the food services program. They further added that their duties and hours as Registered Dietitian come first and after this role is fulfilled, they complete their hours as Nutrition Supervisor. The RD / Nutrition Supervisor advised that they took on the additional role of Nutrition Supervisor when the previous Nutrition Supervisor left on long-term disability leave. The home did not advertise for this position as the cost savings were re-allocated within the home towards infection prevention and control. As far as they are aware, they will be both the home's RD and Nutrition Supervisor going forward and are aware that they do not meet the hours in the regulations to carry out the duties as both RD and Nutrition Supervisor.

During an interview with Inspector #593 December 18, 2014, the Administrator advised that along with the home's RD, the Housekeeping Supervisor is also qualified to lead the nutrition department and assist as required. The Administrator believed that because they have two staff members qualified to lead this program, they are meeting the required hours as outlined in the regulations however pursuant to s. 75 (3) hours on-site cannot be spend fulfilling other responsibilities.

The home has occupancy for 177 residents and at the time of the inspection the occupancy of the home was above 97 percent. Pursuant to O. Reg. 79/10, s. 75 (4) the minimum hours a nutrition manager is required to be on site at the home working in the capacity of nutrition manager is full-time hours. As such, the licensee has failed to ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including an hours spent fulfilling other responsibilities. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 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

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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 10th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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