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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 28, 2013	2013_190159_0035	H-000795-13	Other

Licensee/Titulaire de permis

PLEASANT MANOR RETIREMENT VILLAGE
15 Elden Street, Box 500, Virgil, ON, L0S-1T0

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

PLEASANT MANOR RETIREMENT VILLAGE
15 Elden Street, Box 500, Virgil, ON, L0S-1T0

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 22, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Therapeutic Recreation Manager, Food Service Supervisor, registered nursing staff, President of the Family Council, Personal Support Workers (PSWs) dietary staff and residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, reviewed health record, Residents' Counsil meeting minutes, Family Council meeting minutes and menus.

The following Inspection Protocols were used during this inspection:
Dining Observation

Family Council

Residents' Council

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to residents, including residents #00001, resident #00002, resident # 00003 and resident #0004.
Resident # 00002 and resident #00004s' the plans of care stated residents required all fluids to be thickened to honey consistency, however, November, 2013, on a specified date the residents were served fluids at lunch which appeared to be thickened to pudding consistency.
November,2013,on a specified date resident #00003 did not receive thickened fluids as indicated in the plan of care and the diet list. The diet sheet and the plan of care for the resident identified to be provided nectar consistency thickened fluids, however, the resident was served at lunch pudding consistency thickened fluids. The observations were validated by the Food Service Manager. [s. 6. (7)]

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 the care set out in the plan of care is provided to all residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that planned menu items were offered and available at each meal and snack.
Therapeutic menu for minced and pureed diets for the lunch November 22, 2013, indicated raison and carrot salad was to be offered, however, minced and pureed carrot salad was not prepared nor available to offer residents. Staff confirmed that the carrot salad was not available and the residents were not offered.
The planned menu indicated whole wheat bread was to be offered every day at lunch and dinner, however, bread was not offered at lunch on November 22, 2013. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the food production, system were prepared, stored and served using method to prevent adulteration, contamination and food borne illness.
On November 22, 2013, uncovered beverages (milk, juices) were observed on dining room tables located in the main dining room and in the SunroomCafé, both of which were open concept areas at 1200 hours. Lunch was scheduled to be served at 1215 hours in the café and 1230 hours in the main dining room and residents were therefore not seated at the tables. The placement of beverages on tables too far in advance of resident arrival poses a potential contamination risk (potential for other residents or visitors to drink from the glasses) and a rise in temperature for the dairy-based beverages. [s. 72. (3) (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 ensuring that all food and fluids in the food production, system are prepared, stored and served using method to prevent adulteration, contamination and food borne illness, to be implemented voluntarily.

WN #4: 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents were provided personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
November, 2013, on a specified date resident #00001 was served meal at 1215 hours, however, the resident had no initiation of self feeding and no encouragement from staff. At 1235 hours a staff member started to feed the resident. The plan indicated staff to provide cueing and encouragement and assistance to consume meal.
Resident #00005 in Café Sunroom was observed being assisted with eating by the nursing staff. The staff left before the resident had finished eating dessert and the beverages. The resident sat with the dessert in front with no assistance or encouragement. The plan of care identified staff to encourage resident to complete fluid and meals. [s. 73. (1) 9.]

Issued on this 28th day of November, 2013

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

Asha Sehgal