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) :	DEBORA SAVILLE (192), ASHA SEHGAL (159)
Inspection No. / No de l'inspection :	2011_027192_0043
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Sept 28,29 Oct 2,3,4,5,6 AS Oct 12, 13, 14, 19, 20, 21, 24, 25, 26, Nov 25, Dec 7, 16, 19, 22, 2011
Licensee / Titulaire de permis :	KING NURSING HOME LIMITED 49 Sterne Street, Bolton, ON, L7E-1B9
LTC Home / Foyer de SLD :	KING NURSING HOME 49 Sterne Street, Bolton, ON, L7E-1B9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JANICE KING

To KING NURSING HOME LIMITED, 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure there is a written plan of care, for each resident, that sets out clear direction to staff and others who provide direct care to the resident.

The plan shall be implemented.

The plan shall be submitted electronically to Nursing Inspector, Debora Saville of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at debora.saville@ontario.ca by January 10, 2012.

Grounds / Motifs :

1. The licensee failed to ensure that the plan of care sets out clear direction for the staff and others who provide direct care to the resident. [s.6(1)c]

a) A specified resident is identified to require assistance with toileting. The resident exhibits ongoing behaviours and has sustained several falls through the month of September 2011. There is no direction in the plan of care to address the resident's physical needs, such as the frequency of toileting, in order to improve comfort and potentially minimize behaviours and falls. Staff interviewed indicated the resident is toileted three - four times during the day, but could not identify a schedule for toileting.

b) A specified resident is identified to have an injury, and was observed to have redness and tenderness in another area in September 2011. During interview with staff routinely responsible for the resident's care, it was identified that a device is used to download pressure from designated areas while the resident is in bed. This intervention is not included in the plan of care for direction to all staff and others who provide direct care.

c) The plan of care indicates that a specified resident is on an antibiotic. A review of the physicians orders indicates that the resident was last on antibiotic three months earlier. The plan of care was not updated to reflect this change in status.

d) The plan of care in effect on September 29, 2011 indicates that a specified resident is to be supervised by 1 staff member to use the toilet, goes to the bathroom on her own and needs to be toileted by staff after each meal and as necessary. Staff interviewed indicate that the resident is routinely taken to the bathroom immediately following meals. If not assisted by staff, behaviours identified in the plan of care can occur. The plan of care under bladder function and toileting indicate the need for Personal Support Worker assistance but do not include a routine toileting schedule identified by Personal Support Workers to be effective in managing the resident's continence.
{It is noted that the plan of care was updated during the course of this inspection.}

e) For a specified resident , instructions related to transferring to the toilet vary; under Toileting - Two staff members to provide weight bearing support for toileting to transfer on/off the toilet . Under Transfers - One staff member to provide physical assistance by interlocking arms with resident. The Personal Support Worker interviewed indicated that the resident is a one person transfer for toileting.

f) The plan of care for a specified resident indicates that the resident "uses 2 bedrails for mobility while in bed. The resident was observed with one bed rail in place. Interview with resident and a Personal Support Worker confirm use of one bed rail up at all times.

g) The plan of care for a specified resident does not provide direction to staff related to positioning in the wheelchair. On October 3, 2011 the resident was observed in the lounge, sitting upright in a wheelchair. Two staff members approached the resident to adjust clothing, a slight disagreement arose between the care givers with one care giver insisting the resident's chair be reclined. During interview on October 6, 2011 a Personal Support Worker identified that the resident's wheelchair needs to be reclined as the resident is at risk of falls and is unpredictable. It is noted that the resident has fallen from the chair. There is no clear direction to staff related to when the resident's chair should be reclined or related to positioning for meals.

h) A specified resident was noted on September 28 and 29, 2011 sitting in a wheelchair with disheveled hair and no eye glasses in place. The plan of care under Dressing indicates: "Wears glasses at all times. Ensure glasses are cleaned and adorned at all times when up in wheelchair." Under vision the plan of care states: "has eyeglasses but refuses to keep them on." Staff interviewed indicated that the resident does not wear glasses. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 20, 2012

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall prepare and submit a plan to ensuring that for each resident demonstrating responsive behaviours;
a) the behavioural triggers for the resident are identified, where possible; and
b) actions are taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions are documented.

The plan shall be implemented.

The plan shall be submitted electronically to Debora Saville, Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at debora.saville@ontario.ca by January 10, 2012.

Grounds / Motifs :

1. The licensee has failed to ensure that behavioural triggers have been identified for the following residents.

a) A specified resident is identified to have responsive behaviours. A review of the plan of care identified that triggers have not been identified for these behaviours. The resident has a prescription for medication to be given for severe agitation. On October 3, 2011 the resident was noted to have a painful injury. At approximately 2130 the resident required a specified treatment affecting the injured area. When this was attempted the resident struck out at staff. Medication was administered to control the resident's actions. Pain was not considered as a trigger for the behaviour and analgesic was not offered to the resident.

b) The licensee has failed to ensure that behavioural triggers have been identified for a specified resident who exhibits responsive behaviors daily. The resident is identified to put self and others at risk on a daily basis. There is no record of assessment of triggers related to behaviours exhibited. Documentation and interview include potential triggers such as pain as a result of multiple falls with injury. A physiotherapy note on September 23, 2011 indicates that the resident should be observed for signs of fatigue; the plan of care was not updated to include interventions related to fatigue. The resident requires assistance with toileting; the need for toileting has not been considered as a trigger and no toileting schedule has been established.

c) The licensee has failed to ensure that behavioural triggers have been identified for a specified resident. The plan of care indicates that the resident demonstrates specified behaviours. Dementia Observation Records have been initiated but triggers for behaviours exhibited have not been established. There is no indication that physical or psychological needs have been considered for behaviours exhibited. Staff interviewed are able to identify the type of behaviour exhibited, but are unable to verbalize the possible triggers for the behaviour. (192)
2. The licensee has failed to ensure that actions taken to meet the needs of the resident with responsive behaviours include assessment, reassessment , interventions and documentation of the resident's responses to the interventions.

a) A specified resident exhibits responsive behaviours daily. The only intervention documented through September 2011 was the use of medication. Non-pharmaceutical interventions identified in the plan of care such as using a calm voice, cueing to take deep breaths, 1:1 monitoring or other interventions were not documented through the month of September 2011. Pharmaceutical interventions initiated were not always evaluated.

b) The documentation completed by Personal Support Workers on the Flow sheet indicates that a specified resident exhibited responsive behaviours 14 of 16 days and a sad, pained, worried facial expression 15 of 16 days between September 1 and 16, 2011. This documentation does not include documentation of interventions attempted or the resident's response to those interventions. A review of the progress notes finds no documented behaviours for the month of September 2011.

c) A specified resident demonstrated responsive behaviours. The resident was observed wandering on the home area on October 5, 2011, the wandering behaviour observed was not recorded in the residents medical record. Behaviours documented on October 2 and 4, 2011 do not include interventions used or the effectiveness of those interventions.

d) A review of the progress notes for a specified resident identified 3 documented incidents of verbal aggression during the month of September in spite of almost daily recorded incidents of aggression on the flow sheets and within DOS documentation. Interventions and evaluation of those interventions are not consistently recorded in behaviour notes within the progress notes. It is also noted that the identified behaviour is not always addressed. A contracted service was provided even though the resident was resistive. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 27, 2012

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. 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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure prepare and submit a plan ensuring that the food and fluid are being served to all residents at a temperature that is both safe and palatable to residents. Including, but not limited to the recording of food temperatures for all food items (including pureed foods) taken at the service point and also in the kitchen before the food is delivered to the resident's home area.
The plan shall be implemented.
The plan shall be submitted electronically to Nursing Inspector, Debora Saville, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office, at debora.saville@ontario.ca by January 5, 2012.

Grounds / Motifs :

1. Food and fluids were not served at a temperatures that was both safe and palatable to the residents.

a) October 13, 2011, at the observed lunch meal 1st floor at 12:25 pm food temperatures were tested in the kitchen in the presence of the cook and a dietary aide. The cold food temperatures recorded were found to be: coleslaw 12.23 degree Celsius, beet salad 20.23 degree Celsius, corned beef sandwiches 13.2 degree Celsius and minced corned beef sandwiches 11.4 degree Celsius, cold foods should have been 5 degree Celsius or less.

b) Food temperatures were tested by Inspector #192 on the 3rd floor at 12:15 pm and were recorded : Cream of celery pureed soup 58.7 degree Celsius, the hot food temperatures should have been 60 degree Celsius or above. The cold foods tested were found to be: beet salad 21.2 degree Celsius, mandarine oranges 14.4, degree Celsius, corned beef sandwiches 17.2, degree Celsius, and creamy coleslaw 13.3 degree Celcius. Hot and cold food not served at safe temperatures compromises palatability, reduces food intake and also increases risk for food contamination. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2012

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare and submit a plan ensuring that when a resident's care needs change, they are reassessed and the plan of care is reviewed and revised.
The plan shall be implemented.
The plan shall be submitted electronically to Debora Saville, Nursing Inspector, Ministry or Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at debora.saville@ontario.ca by January 10, 2012.

Grounds / Motifs :

1. A specified resident sustained a medical emergency, was hospitalized and returned to the home with a new diagnosis. The plan of care has not been updated to reflect this new diagnosis or interventions. (192)
2. The licensee failed to ensure that a specified resident was reassessed and the plan of care reviewed and revised when the resident's care needs change. On September 6, 2011 the resident was identified to have redness and tenderness of a designated area. No assessment of this pain was completed. The plan of care was not updated to include this new source of pain or interventions to protect the area from further tissue damage and promote comfort. (192)
3. A specified resident was not reassessed and the plan of care not reviewed and revised when care set out in plan was not effective in relation to constipation. October 14, 2011, the plan of care for a specified resident was reviewed and noted documented nutritional interventions for constipation were initiated. Food and fluid intake records for a four month period indicated that the resident had been refusing the designated intervention. October 14, 2011, a review of medical administration record and the daily bowel movement flow sheets had identified that the resident had an increase in the amount of constipation and has been requiring use of laxatives frequently without an evaluation of the effectiveness of nutritional interventions. The registered dietitian verified that nutritional intervention for constipation initiated had not been evaluated and the plan of care was not revised. The registered dietitian confirmed that a referral had not come through in any of these instances. (159)
4. On October 14, 2011, the progress notes for a specified resident were reviewed and it was noted that a referral was made to the registered dietitian by the registered staff. The contributing factor initiating the referral was the resident had undesirable weight change. The dietitian's assessment documented on the referral form stated "review of progress notes and discussion with the Registered Practical Nurse reveals no change in status from last month and no new interventions are required". This was contrary to the home's computerized monthly weight record and the referral made by the nursing staff to the dietitian for weight loss. The weight changes were not assessed with action taken and outcomes evaluated. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 20, 2012

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. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall review and revise the plan of care for a specified resident related to oral intake, weight changes and dehydration and shall consider different approaches to meet the needs of the resident.

The licensee shall review and revise the plan of care for a specified resident related to reducing falls and mitigating injury related to falls and shall consider different approaches to meet the needs of the resident.

Grounds / Motifs :

1. The plan of care for a specified resident was not revised and different approaches considered when care set out in the plan was not effective in relation to significant weight loss and poor oral intake. Interventions for weight loss and poor intake were implemented in 2011, however, resident continued to have poor oral intake, loose weight and without evaluation of the effectiveness of the strategies. The triggered resident Assessment Protocol (RAP summary related to Nutrition and Hydration, completed by the Registered Dietition, indicates resident's nutrition intake is poor, the resident is not consuming meals and snacks. However, the assessment completed by the dietitian did not include an evaluation and effectiveness of strategies/interventions in relation to unplanned weight loss and poor intake. There is no documentation regarding any different approaches or different nutritional interventions tried during this six month period. (159)
2. A specified resident is at a high risk for falls as identified in assessment completed in 2011. The plan of care in use on September 28, 2011 indicates that staff should; reinforce need to call for assistance, clip call bell to pillow at all times, assist resident to walk as is at risk of falls and 1 side rail at all times when in bed. Interview with the director of care confirms that strategies to reduce or mitigate falls are not currently in place. Interventions within the plan of care were ineffective in preventing falls, no new interventions were included in the plan of care following two falls sustained by the resident in 2011. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 20, 2012

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 : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that care set out in the plan of care, for specified residents, is provided to the residents as specified in the plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that care set out in the plan of care is provided as specified in the plan. The plan of care for a specified resident indicates "staff to escort". On October 3, 2011 the resident was observed ambulating independently in the lounge. On October 6, 2011 it was reported that the resident had sustained a fall, while ambulating independently. (192)
2. The licensee has failed to ensure that care set out in the plan of care is provided as specified in the plan of care. The plan of care for the specified resident indicates "staff ensure clothing and foot wear are clean and appropriate". The resident was observed on October 3, 2011 with old food on the clothing, a sweater bunched up behind the back and not fully donned and a food soiled blanket was placed on the lap. On October 4, 2011 the resident was noted to be sitting in the lounge area with the same soiled blanket wrapped around the arms and shoulders. (192)
3. The licensee has failed to ensure that care set out in the plan of care is provided as specified in the plan. The plan of care for the specified resident indicates that the PSW is to instruct the resident regarding a specific activity of daily living. Interview with the PSW responsible for the resident's care indicated that staff complete part of the activity of daily living for the resident and instruct the resident on part of the activity. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 10, 2012

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 : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other for the following residents.

Four residents specified.

Grounds / Motifs :

1. The pain assessment completed for a specified resident indicated that the resident stated the pain never goes away. The Minimum Data Set (MDS) assessment completed on a specified date in 2011 states that "pain is present less than daily". Flow sheets completed by the Personal Support Workers indicate that for the month of September 2011 pain was present on 18 of 30 days and 3 of 30 nights. Weekly pain assessments completed through the month of September 2011 indicate that regular analgesic is effective, no complaints of breakthrough pain. Assessments related to pain are inconsistent and the presence of pain for the specified resident is not being addressed. (192)
2. On a specified date a contracted service provider identified that a specified resident had a vulnerable pressure point that was reddened and tender to touch. The specified resident's Power of Attorney also made staff aware of complaints of pain voiced by the resident. The specified resident is identified in the plan of care to have pain from other sources. Weekly pain assessments completed over a specified time in 2011 indicate that there was no breakthrough pain. These new sources of pain were not included in the weekly pain assessments completed. (192)
3. A specified resident is on a regular dose of medication and has weekly pain assessments completed. Not all sources of pain were considered in completing the weekly pain assessment. The assessments completed by different nursing staff are not integrated and consistent with the care needs of the resident. (192)
4. A specified resident has multiple wounds. Analgesic is ordered for pain relief including medication for breakthrough pain. Personal Support Workers documented on the flow sheet that the resident was in pain. Weekly pain assessment completed by registered staff indicates that the resident had no pain for the previous 7 days. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 10, 2012

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Ministére de la Santé et des Soins de longue durée

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Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that standardized recipes are consistently followed and that recipes are individualized for the number of servings and quantities required as per the production sheet.
The plan shall be implemented.
The plan shall be submitted electronically to Nursing Inspector, Debora Saville, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office, at debora.saville@ontario.ca by January 5, 2012.

Grounds / Motifs :

1. Standardized recipes at lunch meal October 13, 2011 were not consistently followed.

a) For cream of celery soup ingredients were not weighed or measured. Dietary staff was observed making roux, mixing flour and margarine without measuring or weighing ingredients.
Recipe for cream of celery soup was not individualized for the number of servings required. The recipe available for the cream soup was for 55 servings, where as the quantities required on the production sheet were for 85 servings. Dietary staff (cook) interviewed confirmed that he had simply multiply out the recipe for 55 serving, without making adjustments in amount of liquid and other ingredients. The consistency of the cream soup was thin.

b) Canned diced beets prepared with vinegar and sugar were served at lunch, the planned menu for that day had pickle beets. Recipe for pickle beets was not followed. The recipe called for 6.58 liter beets for 55 servings, only 5.68 liter canned diced beets were used for 55 servings. Lack of adherence to recipe compromises food quality. (159)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

Ministère 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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 22nd day of December, 2011

Signature of Inspector / Signature de l'inspecteur : Debora Saville

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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