Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Aug 11, 2014	2014_278539_0013	H-000556-14	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5

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

VALERIE GOLDRUP (539), ASHA SEHGAL (159), DARIA TRZOS (561), DIANNE BARSEVICH (581), LALEH NEWELL (147), LEAH CURLE (585)

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): May 26, 27, 28, 29, 30 and June 3, 4, 5, 6, 9,10, 11, 2014

The following log numbers were completed during this inspection: H-000578-13, H-000359-14, H-000284-14, H-000047-14, H-000316-14, H-000317-14,H-000339-14, H-000052-14, H-000591-14. The following follow-ups were completed during this inspection: H-000651-14, H-000959-13, H-000958-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nurse Clinician, Acting Nurse Manager, Resident Assessment Instrument (RAI) Coordinator, Infection Control Nurse, Skin Care Nurse, Nursing Clerk, Registered Nursing staff including Registered Practical
Nurses (RPN) and Registered Nurses (RN), Personal Support Workers (PSW), Physician, Physiotherapist, Social Service Worker, Registered Dietitian (RD), Food Service Manager, Cook, Dietary Workers/Aides, Environmental Manager, Maintenance staff, Housekeeping staff, Laundry staff, residents and family members of residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed health care records, investigation reports, human resource files, relevant policies, procedures and practices and interviewed staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
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
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. A) The licensee did not ensure that resident #402 was protected from physical abuse by a staff member.

In March, 2014, resident #402 reported to their family that an identified PSW was

rough with the resident during care. As a result the resident injured their wrist in the process as the PSW “yanked” on their wrist while assisting them in bed while providing the resident with continence care.

Interview with resident and review of the home's internal investigation notes indicated that this was the first time this PSW had provided care to the resident and was not aware of the resident's regular routine for continence care while in bed.

The resident's family member reported this allegation of abuse to the Registered Nursing staff at which time an assessment of the affected area was completed by the Registered Staff.

The home notified the Ministry of Health, the Physician and the Police of the alleged incident and submitted a Critical Incident report to the Ministry of Health.

The PSW involved in the incident was terminated after the home's internal investigation was completed.

B) The licensee did not ensure that resident #404 was protected from physical abuse by a staff member.

In March, 2014, a nursing student witnessed a PSW forcefully pushing resident #404's head back so that their head hit the back of the wheelchair headrest. Immediately after the witnessed incident the nursing student overheard the resident scream out in pain; as a result of this incident the resident sustained a bruise/hematoma on their head.

The nursing student reported the witnessed incident to the Registered Nursing staff at which time a head to toe assessment was completed by the Registered Nursing staff. The home removed the PSW from the home pending investigation. The home notified the Ministry of Health, the Physician and the Police and submitted a Critical Incident report to the Ministry of Health.

The PSW involved in the incident was terminated after the home's internal investigation was completed. [s. 19. (1)] (147) [s. 19. (1)]

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. 19. Generators

Specifically failed to comply with the following:

s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Findings/Faits saillants :

1. The home (classified as a C home) did not have guaranteed access to a generator that was operational within 3 hours of the power outage that affected the home between 6:15 p.m. on July 8, 2013 and 3:30 a.m. on July 9, 2013 and that could maintain 1) the heating system 2) emergency lighting in hallways, corridors, stairways and exits, 3) essential services including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, 4) the resident-staff communication and response system, 5) elevators, 6) life support and safety and emergency equipment.

The City of Mississauga was affected by a wide area power outage due to a storm beginning at approximately 5:30 p.m July 8, 2013. The home was without power to operate their heating system (if needed), dietary services equipment, resident-staff communication and response system, lighting, elevators, safety and emergency equipment and life support equipment. The home was able to operate some emergency equipment such as the fire panel and alarms and some corridor lighting for approximately 7 hours as they were connected to a battery. According to management staff, 9 residents who were outside of the home or not on their own home floor at the time of the outage became stranded on the main floor for approximately 8-9 hours. The home's 2 elevators were not functional at the time and could not be used to transport residents back to their rooms. All 9 residents were not able to use the stairs and the home did not have any alternative methods in which to transport them from floor to floor. Residents were therefore accommodated on mattresses which were placed on the floor within the dining room. The home's cold holding equipment was

not supplied with any back up power; however, according to the Food Service Manager, the temperature of the refrigerators did not rise high enough to affect perishable foods. None of the meals were affected and residents received their planned menu items.

The home's resident-staff communication and response system was not functional throughout the power outage (8-9 hours). No alternative system was in place other than more frequent monitoring of residents by staff. Therapeutic air surfaces deflated and residents had to be transferred to foam mattresses. Many of the electric beds had to be manually modified. The door locking system which operates on electricity and is on all stairwell and perimeter doors was not functional and had to be manually monitored by staff.

The licensee did not comply with the Order made on August 28, 2013 because the licensee still does not have guaranteed access to a generator that would be operational within three hours of a power outage. The licensee has mitigated some of the risk to residents identified on July 8 and 9, 2013 by entering into an agreement with a generator supplier for access to a generator; however, that access is subject to conditions (generator availability, weather, road conditions). Based on the scope of the non-compliance, the risk to residents should a generator not be operational within three hours of a power outage, and the compliance history, an Order is warranted. Because the licensee now has access to a generator and has indicated its intention to purchase a generator in 2015, the compliance date is set for June 1, 2015. [s. 19. (4)]

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. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).**

**s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).**

**s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).**

**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 O. Reg. 79/10, s. 72 (3).**

**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 failed to ensure that the food production system, at a minimum, provided for preparation of all menu items according to the planned menu.

A) On May 30, 2014, the lunch menu listed low sodium pepper potato soup. The standardized recipe called for 10 ml of white pepper and no salt. During meal production, a Cook was observed pouring white pepper in a #12 scoop, and then added it to the soup. The Cook then partially filled the same #12 scoop with salt and added it to the soup. The Cook confirmed they added salt to the soup.

B) On May 30, 2014, the lunch menu listed fish and chips. The standardized recipe for the puree fish instructed that tartar sauce be added during the puree process. The Dietary staff who pureed the fish stated the puree blend contained only fish and broth.

C) On May 30, 2014, the lunch menu listed fresh diced melon. The standardized

recipe called for cantaloupe and honeydew melon. During the lunch meal preparation, a Dietary Aide was observed portioning watermelon in bowls and reported they were portioning six regular texture watermelon for the second floor, and six regular texture watermelon for third floor. The production sheet indicated that 12 regular texture servings of watermelon were to be produced for second floor, and 12 regular texture watermelon servings for the third floor.

D) On June 4, 2014, during lunch preparation, the Cook stated they needed to prepare seven servings of puree soup for the minced and pureed diets for the first floor dining area for residents coming from second and third floor. The production sheet called for nine servings.

E) On June 4, 2014, a Dietary Aide was observed preparing rye turkey sandwiches and was using a #8 scoop for the sandwich filling. The recipe instructed use of a #12 scoop for the filling.

F) On June 5, 2014, a Cook was preparing the pork chopettes for supper. The Cook reported they were going to prepare 71 regular, 31 minced, and 27 pureed texture pork chopettes, five for show plates, and five for extras, totaling to 139 chopettes. The production sheet called for 145 servings. [s. 72. (2) (d)]

2. The licensee failed to ensure that the food production system, provided communication to residents and staff of any menu substitutions.

A)On May 30, 2014, the posted daily menu listed croissants for lunch. During meal service, croissants were not served, and instead, dinner rolls were served. The Food Service Manager first stated the croissants did not come in, and then later clarified that they forgot to order the croissants. The substitution was not communicated to residents and staff on the posted daily menu. [s. 72. (2) (f)]

3. The licensee failed to ensure that the food production system, provided documentation on the production sheets of any menu substitutions.

During the course of the inspection, several menu substitutions were made and substitutions were not documented on the production sheets.

A) On May 26, 2014, white bread was served with the tuna salad plate for lunch meal service on the second floor. The daily menu stated wheat rolls were to be served with

the tuna salad plate. The substitution was not documented on the production sheets.

B) On May 30, 2014, a mixture of medallion shaped fries and straight cut fries were prepared and served for lunch. The posted menu called for chips, however the recipe called for straight cut fries. The Food Service Manager confirmed that both forms of fries were served as they decided to use up the rest of the medallion fries from the previous menu cycle. The substitution was not documented on the production sheets.

C) On May 30, 2014, watermelon was prepared and served on all floors in all textures for lunch. The posted menu stated fresh diced melon, however the recipe for the called for cantaloupe and honeydew. The Food Service Supervisor confirmed that the recipe was not followed. The substitution was not documented on the production sheets.

D) On May 30, 2014, puree texture menu listed French fries to be served at lunch. Mashed potatoes were observed to be prepared and served to puree textured diet residents on third floor. The change was not documented on the production sheets.

E) On May 30, 2014, dinner rolls were served with the cottage cheese and fruit plate. The daily menu listed croissants. Following the meal, the Food Service Supervisor stated the croissants never came in, and then later clarified that they forgot to order the croissants. The substitution was not documented on the production sheets.

F) On June 3, 2014, lemon poppy seed bread was served on second floor for lunch. The posted menu listed muffins. The Food Service Supervisor confirmed that they were first made aware the recipe was not followed at the beginning of the lunch. The substitution was not documented on the production sheets.

G) The Food & Nutritional Services policy titled Production Sheets -(FNSFP060), effective January 1, 2011, stated that the Food Services Manager or Designate was responsible to make changes to the production sheet prior to meal service as required, and cooks were to indicate on the production sheets any overproduction or shortages, and any menu substitutions made and for what reason changes were made. [s. 72. (2) (g)]

4. The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance, and food quality.

A) During stage 1 of the Resident Quality Inspection, resident #30 stated the home's food quality was not good, and the meat was very dry. Resident #28 reported the meat and fish were a lesser quality, very hard, dry, and tasteless.

B) Prior to the start of lunch service on June 3, 2014, on second floor, pre-portioned bowls of strawberry ice cream were observed on a trolley in the hallway, and appeared half melted. The ice cream bowls were placed in the freezer on a tray during the main course service and removed from the freezer for dessert. Many bowls did not have a visible scoop shape left at the time of service to residents, compromising the appearance of the food. The Food Service Manager stated that new portions of ice cream should have been provided, rather than serving melted ice cream.

C) On June 4, 2014, sweet potato fries were served. During meal service in the first floor dining room, the regular texture sweet potato fries served appeared soggy, compromising the taste and appearance of the food.

D) For the supper meal on June 5, 2014, pork choppettes were on the menu. The Cook reported the product was pre-cooked. Product details stated the pork was a fully cooked pork chop shaped pattie, and contained textured vegetable protein, indicating the meat was processed. The choppettes were cooked almost one hour before served to residents and held in the oven until the meal, which resulted in reduced preservation of taste and appearance. Some of the choppettes appeared overcooked when they were pulled out of the oven. During meal service, the choppette was sampled and was hard on the outside, and spongy on the inside, and did not characterize a texture of pork. [s. 72. (3) (a)]

5. The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored, and served using methods to prevent adulteration, contamination, and food borne illness.

A) During supper meal preparation on June 5, 2014, in the kitchen, observed a Dietary staff handle raw meat in the sink. After handling the meat, the staff touched a counter surface and fridge handle with their bare hands without washing their hands or cleaning the contaminated surfaces.

The Dietary staff reported the home's expectation for staff was to wash hands immediately after touching raw meats and touching other surfaces. The Food Service

Manager confirmed the expectation for staff to wash their hands immediately after touching raw meat before touching other surfaces.

The home's Food and Nutritional Services Manual Policy for Safe Food Handling-(FNSFS050), stated that staff must wash their hands after handling raw food items.

B) During supper meal preparation June 5, 2014, observed a Dietary staff lick their finger and flip pages in the recipe book. The Food Service Manager confirmed the expectation for staff to wash their hands immediately after their hands come in contact with their mouth. [s. 72. (3) (b)]

Additional Required Actions:

CO # - 003, 006 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. 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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 food and fluids were served at a temperature that was both safe and palatable to the residents.

The temperature record forms at the dining room serveries stated that the temperature

expectations were that cold foods were to be served at 4 degrees Celsius or lower, and hot foods be served at 60 degrees Celsius or higher. The Food Service Supervisor confirmed this expectation.(585)

A) Foods were not served at a temperature that was both safe and palatable to the residents at the lunch meal June 3, 2014. Hot food temperatures were tested and recorded during the service and chicken strips were found at 40 degrees Celsius and cubed potatoes at 30 degrees Celsius. The temperature monitoring record indicated that the foods were to be served above 60 degrees Celsius. The hot food was held and served at temperatures that were not safe and palatable. (159)

B) During the lunch meal service on May 30, 2014, on third floor, regular textured potato fries were probed at 48.1 degrees Celsius, regular texture coleslaw at 12.3 degrees Celsius, and minced coleslaw at 10.3 degrees Celsius. Resident # 504 who received tray service reported their fries arrived cold.(585)

C) During lunch meal service on June 4, 2014, on the first floor in the kitchen, regular texture sweet potato fries were recorded at 47.6 degrees Celsius,and minced egg and broccoli frittata were 59 degrees Celsius. Regular texture turkey salad sandwich on white bread was sitting in the middle of the steam table, and was 16 degrees Celsius. (585)

D) During the supper meal service on June 5, 2014, on the third floor, minced steak was 52.6 degrees Celsius, puree steak was 50.6 degrees Celsius, puree pork was 53.9 degrees Celsius, minced peppers and mushrooms were 56 degrees Celsius, puree peppers and mushroom were 49.4 degrees Celsius, and minced herbed potatoes was 55.4 degrees Celsius. Resident #505 stated the beef was not hot enough.(585)

E) During breakfast service on June 6, 2014, on third floor, regular texture fruit was 11.4 degrees Celsius, minced fruit was 15.2 degrees Celsius, and puree fruit was 13.3 degrees Celsius. Regular toast was sitting in the steam table and was 43.7 degrees Celsius.(585)

F) The Resident's Council meeting minutes in December, 2013 documented complaints that the French fries were cold. The Food Committee meeting minutes from March, 2014 documented complaints that some foods were not hot enough.(585)

G) During the Resident Quality Inspection, resident #30 reported that sometimes the food was cold, and resident #28 stated the dinner entrée was sometimes cold.(585) [s. 73. (1) 6.]

2. The licensee did not ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The plan of care for resident #101 indicated they were to be provided beverages in a mug with a disposable lid and a straw.

During the lunch meal observation on May 26, 2014, the resident received beverages in regular glasses. The resident was observed attempting to drink apple juice independently; the juice was dripping down off the glass.

The plan of care had identified that the resident was to be provided adaptive aides for eating due to tremors as a result of Parkinson condition. The resident was identified to be at risk for choking and swallowing difficulty. [s. 73. (1) 9.]

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 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 did not ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Review of the home's skin and wound program related to skin tears, that was currently in use, was not in compliance with and was not implemented in accordance with applicable requirement under the Act.

Skin Care and Wound Management program, revised April, 2010 and reviewed on February 3, 2014, did not direct Registered Nursing staff to make a referral to a Registered Dietitian when a resident had a skin tear. The policy stated that a referral to a Registered Dietitian is made for only stage 2, 3, 4, and X wounds.

Registered Nursing staff were not aware that skin tears needed referrals to a Registered Dietitian. Director of Care confirmed that the policy was not updated but staff were aware that all skin tears needed to be referred to a Registered Dietitian. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee did not ensure that the home's Hydration Monitoring policy-(RCS C-40), dated September 4, 2013, was complied with.

A) The home's policy stated the Registered Nursing staff would initiate a dietary referral form for each resident who has not consumed their required amount of fluids for the 24 hour period over a three day time span. An electronic progress note would be included in the resident's chart identifying the section.

The food and fluid intake records for a period of four months, February 2 to May 28, 2014 confirmed resident #14 had consumed less than the established fluid target of 1530 ml per day each day with an average fluid intake of 1000 ml per day.

A referral to the Registered Dietitian was not initiated when the resident's fluid intake was less than 1000 ml per day for several consecutive days during the months of March, April and May, 2014. Example: April 17, 18, 19, 2014, the resident consumed less than the required amount of fluid for three consecutive days.

A review of clinical health record and interviews with the Registered Dietitian and the Registered Nurse confirmed a referral was not initiated for the resident.

B) The home's policy Recording Food and Fluids Consumed-(FNSCN145),effective

March 11, 2014, for monitoring resident's meal, nourishment and supplement intake,stated resident intake of meals, nourishments and supplements shall be monitored and recorded daily. Food and fluid intake must be recorded immediately following consumption of meal. The intake would be documented using paper intake monitoring or electronic.

Resident #14 did not have intake consistently recorded by staff. A review of intake records were found incomplete, several intake entries were missing in the months of February, March, April, and May, 2014. Examples: Resident #14 meal consumption report for a period of four months had 32 meals, snacks, and fluid intake entries not recorded.

The Registered Dietitian confirmed that assessments could not be accurately completed as a result. The Director of Care and the Registered Nurse confirmed the food and fluid intake records were incomplete and the staff had not complied the policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee did not ensure that where the Act or this Regulation required the licensee to have or put in place any policy, procedure or strategy, that the policy, procedure or strategy was complied with.

The home's policy Bed Rails-(Index I.D: RCS E-05),revised August 10, 2013, stated that the interdisciplinary team would reassess the need for bed rails on a quarterly basis at minimum and document this review on the restraint alternative form.

Resident #39 was assessed on August 14, 2013 for the use of bed rails. The assessment indicated that the resident was to have two bed rails raised while in bed as a Personal Assistance Service Device (PASD).

Resident #24 was assessed on August 14, 2013 for the use of bed rails. The assessment indicated that the resident was to have two bed rails raised while in bed as a PASD.

The Director of Care (DOC)confirmed that since the initial bed rail assessment was completed on August 14, 2013, resident #39 and resident #24 were not re-assessed quarterly. DOC also stated the assessment was not documented on the least restraint alternatives assessment form for the use of bed rails as a PASD as required in their bed rails policy. [s. 8. (1) (b)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident had the right to be treated with courtesy and respect in a way that fully recognized the resident's individuality and respected the resident's dignity.

On a specific day in June, 2014, at 09:55 hours, observed a resident being wheeled in a beige commode shower chair by a Personal Support Worker into the spa room. The resident was wearing a gown that opened in the back. Between the bottom of the chair back and seat as well as the space below the arm rests and the seat, observed the resident's bare skin exposed, and not wearing briefs. Resident was wheeled in the chair by Personal Support Worker in front of nursing station, in the presence of 14 other residents sitting in the hallway. Personal Support Worker stated resident was toileted in their room before going to the spa room, and the resident was wearing the gown as per their preference, and that the resident also had a shirt on, but they did not ensure the resident's shirt was pulled down all the way.

Personal Support Worker stated the expectation is to ensure the resident was covered appropriately during the transfer to the spa room. Interview with Registered Nurse confirmed residents being escorted to the spa room are to be covered with a towel if their gown does not cover their body. [s. 3. (1) 1.] (585) [s. 3. (1) 1.]

2. The licensee did not ensure that every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

Resident #200 was admitted to the home in March, 2013. The consent to medical plan of treatment was not signed by the substitute decision maker until May 2, 2013. Resident received treatment in the home without signed consent from March, 2013 until May, 2013.

There was no documentation in progress notes indicating why the family did not sign the consent and registered staff reported that they did not know why the consent was not signed upon admission. [s. 3. (1) 11. ii.]

3. The licensee failed to ensure that the following rights of residents were fully respected and promoted related to every resident has the right to, have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

During medication observation on the 2nd floor on June 4, 2014, while the RPN was assisting residents in the dining room, the Inspector was sitting behind the nursing station and found a wound care supplies requisition sheet dated Nov 20, 2012 in the garbage bin under the nursing station which included names of several residents,

including the specific wound care products needed for each resident.

Spoke with the RN on the 2nd floor and the Director of Care (DOC) who both confirmed that this form should have been thrown in the shredder and not in the garbage bin in the nursing station as it contained resident's personal health information. [s. 3. (1) 11. iv.]

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 be implemented voluntarily.

WN #7: 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).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of resident #402's plan of care last reviewed on May 9, 2014, Resident Assessment Protocol (RAP) summary for the past three quarters (October 7, 2013, January 6 and April 7, 2014) and interview with the Registered Nursing staff indicated the resident required two person total extensive assistance for toileting and bed mobility.

Interview with the resident and review of the home’s internal investigation notes indicated that on March 13, 2014 one PSW provided continence care to the resident while in bed and did not ensure that the care set out in the plan of care was provided to the resident #402 as specified in the plan which resulted in the resident injuring their wrist in the process. [s. 6. (7)]

2. Resident #40 had a coccyx pressure ulcer stage 4 since admission in 2007. Resident’s plan of care stated the resident was to be turned and repositioned when in bed at least every 2 hours. The resident was to be put back to bed before the end of AM shift and the resident stays in bed till 1130hrs then is up for lunch max 3hrs then is put back to bed.

Resident was observed on June 4, 2014 and was sitting in her wheelchair at 15:45 hours. Interviewed resident and confirmed that staff usually put her back to bed before supper time around 16:30 hours.

Interview with a Personal Support Worker (PSW) that provided direct care to the resident revealed that resident was to be put back to bed before supper time around 16:30 and 17:00 hours. Registered Nursing staff on the evening shift confirmed the same and stated that resident’s care plan was not updated. The nurse confirmed that PSWs that start their shift at 15:00 hours were busy with getting report, doing rounds and taking care of residents’ clothing; therefore resident is put back to bed before supper time.

Reviewed the turning and positioning record and noted that staff had coded on June 3, 2014 that the resident was sitting in their wheelchair for four hours. According to the turning and positioning record for June 12, 2014 the resident had been sitting in their wheelchair since 12:00 hours and was not put back to bed until 16:30 hours.

The Skin Care Nurse confirmed that current care plan directed staff to put resident back to bed at 15:00 hours because they were unable to sit for longer than three hours. Staff did not provide care to the resident as it was specified in the plan of care. [s. 6. (7)]

3. The plan of care for resident #14 indicated resident was to receive high protein high calorie pudding and 250 ml cranberry juice for afternoon snack.

On May 30, 2014, the afternoon snack pass was observed on second floor and a the Personal Support Worker (PSW) served the resident a glass of apple juice and a cookie.

Interview with two PSWs confirmed that there were no labeled special snacks and beverage for the resident, and the resident was served apple juice and a cookie. The diet list/ resident profile information used by the staff personelle did not have the resident's name and special snack listed.

The resident was identified to have a low body mass index and poor oral intake. The care plan for this resident indicated that the resident a required special nourishment, an intervention recommended by the Registered Dietician, for significant unplanned weight loss. Resident observations and staff interviewed confirmed the resident did not receive snacks and beverages as specified in plan. [s. 6. (7)]

4. Resident's plan of care had identified resident was to receive 250 ml lactaid milk at lunch.
The resident was observed in the dining room on May 26, 2014; the resident received 125 ml lactaid milk. The Personal Support Worker (PSW) interviewed reported the special beverages were prepared in the kitchen by the Dietary staff, the resident should have received 250ml lactaid milk. [s. 6. (7)]

5. Resident #500 had a plan of care to follow a gluten free diet as per the resident diet list.

During lunch meal service on May 30, 2014, a Dietary Aide portioned pepper potato soup for resident #500. The therapeutic menu for resident #500 did not list pepper potato soup. The Dietary Aide passed the soup to the Personal Support Worker serving the resident #500. As the Personal Support Worker left the servery to serve the soup, Inspector #585 asked the Dietary Aide if the resident could have the soup. The Dietary Aide consulted with another Dietary staff and determined the soup was not appropriate for resident #500.

The recipe for the pepper potato soup included all-purpose flour. The resident was not served the soup; however the plan of care was not followed as the soup was going to be served to the resident. [s. 6. (7)]

6. Resident #502 had a plan of care to receive double portions of protein at breakfast

and lunch. During meal lunch meal service on May 30, 2014, on third floor, a Dietary Aide did not provide resident #502 with double portions of protein. [s. 6. (7)]

7. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) The Minimum Data Set (MDS) assessment for resident #6 dated February 14, 2013, May 13, 2013, August 12, 2013, and November 11, 2013, indicated that the resident had pneumonia.

Progress notes reviewed on May 29, 2014, noted that the resident had pneumonia only during the month of February, 2013. The RAI Coordinator confirmed that resident #6 did not have pneumonia during the months of May, August, and November, 2013 and that Registered Nursing staff did not resolve the infection in the MDS assessment for these months.

B)The MDS assessment for resident #36 dated May 7, 2013, August 5, 2013 and November 4, 2013 specified that resident had pneumonia.

Progress notes and interview with the RAI Coordinator indicated that resident had pneumonia only during the month of May, 2013. For the months of August, and November, 2013. Registered Nursing staff did not resolve the infection in the MDS assessment. [s. 6. (10) (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 be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

Not all residents were served foods that were nutritious and varied.

At the lunch meal on June 3, 2014, the cubed potatoes served were hard and dry and created risk for choking for residents. Numerous residents voiced concerns over the menu and food quality. The Management staff tasted the potatoes and verified the quality of the food served to residents was not acceptable.

During this Resident Quality Inspection interviews with the residents, families and the multiple dining observations the Ministry of Health (MOH) Inspector validated residents’ concerns and issues related to food quality, planned menu items not always served, running out of menu items, and unsafe hot food temperatures. [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 , to be implemented voluntarily.

WN #9: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident’s health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee did not ensure that a Registered Dietitian who was a member of the staff of the home assessed resident #14’s hydration status and any risk related to hydration.

The food and fluid intake monitoring record indicated the resident’s fluid intake was less than their target fluid requirements. According to the plan of care, their fluid requirements were 1530 ml per day.

The resident had a Nurse Practitioner’s order dated April 11, 2014 for “Push Fluids”. The food and fluid intake records for a period of four months, February, March, April and May, 2014 were reviewed and identified the resident’s fluid intake was most days less than 1000 ml per day. The resident did not meet the fluid requirement of 1530 ml on any day recorded from February to May 29, 2014.

The progress notes dated March 3, 2014, indicated the Registered Dietitian (RD) completed quarterly nutrition assessment, however, the RD did not assess resident’s hydration status.

Resident was identified to be at risk of dehydration. On June 3, 2014 the Registered Dietitian interviewed confirmed the resident did not have an interdisciplinary hydration assessment, interventions and strategies had not been initiated to address resident’s hydration concerns. [s. 26. (4) (a),s. 26. (4) (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 be implemented voluntarily.

WN #10: 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. The licensee did not ensure that resident #14, with the weight changes, was assessed using an interdisciplinary approach and action taken and outcomes were evaluated.

Resident #14 had a significant weight loss of 10.5 per cent over six months from November, 2013 to May, 2014. Progress notes dated March 3, 2014 and May 15, 2014 indicated referrals were initiated related to diet change, weight loss and the resident's return from hospitalization.

The dietary referral response nutrition notes documented by the Registered Dietitian (RD)on March 3, 2014, stated "resident is not meeting estimated nutritional requirements with current intake. Resident has lost weight which is undesirable. Current Body Mass Index (BMI) 19.1, resident remains high nutrition risk". The dietary summary completed on May 15, 2104, by the RD stated resident had further lost weight in the past two months, the weight loss was due to change in intake. However,the review by the RD did not include an assessment of the resident in relation to weight loss and poor food intake. The plan was to continue with current nutrition interventions, which were not effective to address the ongoing poor intake and unplanned weight loss.

A significant weight change i.e weight loss, and poor oral intake were not reassessed using an interdisciplinary approach and outcomes evaluated to address the noted nutritional concerns. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 be implemented voluntarily.

WN #11: 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 the planned menu items were offered and available at each meal and snack.

A)On May 26, 2014 the planned menu posted for lunch consisted of carrot orange soup, tuna and salad plate, wheat roll and pineapple slices. An alternate choice menu was peameal bacon on bun, creamy coleslaw and pumpkin custard.(159)

Residents were not served wheat roll as part of the tune salad plate. Residents were served tossed salad instead of coleslaw with peameal bacon on bun.(159)

The Dietary Aide reported they did not have rolls, and instead, had white and brown bread. (585)

The Cook reported residents were provided tossed salad as they ran out of coleslaw. The coleslaw shortage was not communicated to the residents.(159)

On May 26, 2014 during lunch on the second floor, observed and confirmed with the Dietary Aide they ran out of regular and minced coleslaw, and regular peameal bacon. (585)

Residents voiced their concerns regarding the planned menu not always served, menu substitutions were frequently made, not communicated and also running out of food.(159)

B) On May 30, 2014, the lunch menu for gluten restricted/minced meat diet included gluten free whole grain bread as a second option.

During lunch on the third floor, the Dietary Aide stated there was no grain or starch available to serve the resident. The resident was served non-breaded fish and coleslaw.
Following the meal, the Food Service Manager reported and showed that gluten free bread and buns were available in the kitchen.

C) On May 30, 2014, the lunch menu for the vegetarian diet included options of a vegetarian quesadilla or a cottage cheese and fruit plate. During lunch on the third floor, the Dietary Aide stated the only meal choice for vegetarians was the quesadilla. The vegetarian residents were not offered all planned menu items. The quesadilla

and cottage cheese and fruit plate were available at the time of service.

D) On May 30, 2014, the lunch menu stated croissants were to be served with the cottage cheese plate.During the lunch meal on the third floor, croissants were not available for meal service, and instead, dinner rolls were served.The Food Service Manager stated they forgot to order the croissants.

E) On June 5, 2014, the supper menu for vegetarian diet included vegetarian meat balls and vegetarian beef strips. During supper meal service on third floor, vegetarian meatballs were observed as the only option available for vegetarian residents.The Dietary Aide confirmed the only entree available for vegetarian residents at the time of service was vegetarian meatballs.

F) On June 5, 2014, the supper gluten free menu included gluten free bread. During supper meal service on third floor, gluten free bread was brought up from the kitchen to the floor at 17:50 hours, 20 minutes after meal service started. The home's Food & Nutritional Services policy titled Planned Menu Choices Will Be Prepared at the Same Time-(FNSMS090), effective January 1, 2011, stated that all menu choices for all therapeutic and texture modified diets, should be prepared, provided, and available and ready to be served at the same time for all diet types.

G) During every dining observation conducted during the inspection, staff ran out of food at meal service. On May 30, 2014 during lunch on the third floor, observed and confirmed with the Dietary Aide that they ran out of minced fish. On June 3, 2014 during lunch on the second floor, the Dietary Aide reported to be short of two servings of minced chicken.
On June 4, 2014 during lunch on the first floor in the kitchen servery, observed and confirmed with kitchen staff that they were short five turkey sandwiches, one serving of minced egg frittata, and regular texture beets. On June 5, 2014 during supper on the third floor, observed and confirmed with the Dietary Aide that they ran out of puree bread. On June 6, 2014 during breakfast on the third floor, the Dietary Aide ran out three servings of regular texture fruit. (585) [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 be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents’ linens are changed at least once a week and more often as needed,
(ii) residents’ personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents’ soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents’ lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

The home’s policy-(Index I.D:ES-D-20-30), related to Personal Clothing Procedures for the Lost/Unclaimed Clothing stated all lost clothing concerns of families or visitors were brought to the Resident Services Coordinator or delegate. The Resident Service Coordinator would complete a client service response or complete a missing clothing checklist and forward the response to the nursing and laundry departments. The policy also stated the nursing department would search the home area and the laundry department would search for the missing clothing and report back to the Resident Service Coordinator. The Resident Services Coordinator would report the results back to the family or visitors that made the complaint.

Resident #1, #10, #39, #100 and families who were interviewed stated they had reported missing clothing and personal items to the Management staff. A review of the progress notes for identified residents verified the Registered Nursing staff had documented missing clothing and personal items reported by the residents and the families.

Interviews with the Registered Nursing staff and the Resident Care Co-ordinator/Social Worker confirmed they had not completed a client service response or missing clothing checklist for identified residents.

On May 30, 2014 during the interview with Laundry staff, it was confirmed that they were not aware of any formal process for notification of laundry or tracking of lost items provided for Laundry staff to use. They also indicated that staff would usually verbally tell them when something was missing or family members would come to the laundry and report lost items to them. They would then look in closets and the laundry area to try to find the lost item. They were not aware of any formal process for the documentation of missing items or the results of search.

Residents and the families interviewed confirmed lost clothing and personal items were still missing. The home had not notified them of tracking of lost laundry and personal items or the results of the search.

The procedure for missing clothing and management of personal belonging was not followed and communicated to the resident/ substitute decision maker/family. [s. 89. (1) (a) (iv)]

2. Resident #503 reported to have missing laundry in 2012, and stated they reported it to staff. Review of progress notes stated resident reported missing clothes in September, 2012. The Administrator reported that an initial client services response form should have been completed. The home's policy titled Personal Clothing Procedures, Storage of Lost/Unclaimed Personal Clothing-(Index I.D: ES D-20-30), revised February 1, 2012, stated that the expectation was for staff to complete a missing clothing checklist. The missing clothing checklist was not completed for the resident's missing clothing, and a client services response form was not completed after review of complaint and concerns log. (585) [s. 89. (1) (a) (iv)]

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 be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the Infection Prevention and Control program.

On May 30, 2014, at 11:45 hours, a PSW was observed walking out of a resident's room with gloves on, holding dirty linen They put it in the dirty linen hamper out in the hallway, took their gloves off, took clean towels and proceeded to go into resident's room #328 to assist another resident. PSW never washed or sanitized hands after taking gloves off.

The Policy related to infection prevention and control-(Index I.D: IFC B-15), Routine Practices, revised August 10, 2013, reviewed February 2014, stated that "gloves do not provide the user with total protection from sources of contamination. Consequently, hands must be washed immediately after removal of gloves."

Hand Hygiene Audits were performed in the home every month using the Observation Tool by the Infection Control Nurse. The Observation Tools were reviewed for the

months of March, April and May 2014 and revealed that staff that were audited did not perform "4 moments of hand hygiene". [s. 229. (4)]

2. During breakfast meal service on June 6 2014, on the third floor, a Personal Support Worker was observed feeding resident #500. The Personal Support Worker then went to another table to assist resident #501 and was observed holding the resident's fork and touching the resident's arm. The Personal Support Worker then returned to resident #500 and wiped resident's nose and face with a napkin without washing or sanitizing their hands between the resident interactions.

The home Hand Hygiene Program policy-(Index I.D: IPC H-15), original date January 21, 2010, revised August 10, 2013, identified that staff were to complete hand hygiene before initial contact with a resident, and after contact with a resident or items in their immediate surroundings. [s. 229. (4)]

3. On June 3, 2014, during lunch on second floor, a Personal Support Worker was observed transferring an over-bed table from room 233 to resident #507's room as resident #507 required tray service and did not have their own over-bed table. The table was visibly soiled with dried fluid and crumbs. The Personal Support Worker was observed wiping the over-bed table with hand sanitizer and paper towel, then transferred the table to resident #507's room.

The Personal Support Worker reported that the home's expectation was to use Virox wipes but they did not have any nearby so they used the sanitizer. A Registered Nursing Staff confirmed the home's expectation was to use sanitary wipes if sharing a over-bed table between residents. The Personal Support Worker/Health Care Aide position summary in the Human Resources Manual (Index I. D: HRM D-25-25), revised May 24, 2013, stated that Personal Support Workers/Health Care Aides were responsible to follow disinfection protocols to minimize the spread of infection. The home's policy for Infection Prevention and Control-(IFC B-15), titled Routine Practices, original dated January 30, 2004, revised May 3, 2010, also stated that reusable equipment that had been in direct contact with the resident should be cleaned before use in care with another resident for items that are in touch with intact skin, and equipment that was visibly soiled should be cleaned. [s. 229. (4)]

4. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results

of this screening are available to the licensee.

Resident #200 was admitted to the home on March 26, 2013. According to progress notes the resident did not receive TB screening until May 13, 2013. Infection Control Nurse confirmed that the resident should have had the screening done within 14 days of admission to the home. [s. 229. (10) 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 be implemented voluntarily.

WN #14: 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 failed to ensure that 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.

Review of the home's Abuse or Neglect Policy -(Index ID - A-10), last revised date of April 29, 2011, indicated that the person first having knowledge of when a resident is suspected of abuse or neglect shall immediately inform the Administrator, or if not available the Director of Nursing/or Delegate.

Review of resident #402's clinical chart, home's internal investigation notes and interview with the resident confirmed that on March 13, 2014 a PSW handled the resident roughly while providing care to the resident while in bed. This resulted in the resident hurting their wrist due to being grabbed roughly by the PSW during care. However, the PSW involved in the incident did not report this to the Charge Nurse on the unit, even though the resident did verbalize pain during and after the incident and that there was a verbal altercation between the PSW and the resident during care. The incident was shared by the resident to their family member the following day which was then reported to the Charge Nurse. [s. 20. (1)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident’s plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident’s physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure the use of the Personal Assistance Service Device (PASD) had been consented to by the resident or, if the resident is incapable, a substitute decision maker of the resident with authority to give that consent.

Reviewed the plan of care and Resident #24 was assessed on August 14, 2013, for the use of two bed rails raised as a PASD when in bed. Consent was not signed by the resident’s substitute decision maker until March 19, 2014.

Reviewed the plan of care and Resident #39 was assessed on August 14, 2013, for the use of two bed rails raised as a PASD when in bed. Consent was not signed by the resident’s substitute decision maker until January 16, 2014

Interviewed Registered Nursing staff and they confirmed that consent was not signed for two bed rails to be raised as a PASD at the time of the initial assessment and application of the raised rails. [s. 33. (4) 4.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents’ families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee did not ensured that the home convened semi-annual meetings to advise to such persons of the rights to establish a Family Council.

A review of the Family Council meeting minutes confirmed the last Family Council meeting was convened on May 29, 2012. Interviews with the Administrator and the Social Worker confirmed the Family Council was not established, and the home had not convened semi-annual meetings. [s. 59. (7) (b)]

WN #17: 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. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

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. The licensee did not seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results.

The President of the Residents' Council interviewed stated the Residents' Council had not participated in developing and carrying out the satisfaction survey. This information was verified by the Administrator.

Interviews with the Council Assistant and a review of Residents' Council meeting minutes from 2013 and 2014 confirmed that the advice of the Council was not sought regarding the satisfaction survey specifically related to its development, implementation and in acting on the results. [s. 85. (3)]

2. The licensee did not ensure the results of the survey were documented and made available to the Residents' Council in order to seek their advice regarding the survey.

Interview with the President of Residents' Council, the Council Assistant, the Administrator and the review of meeting minutes for 2013 and 2014 confirmed that the results of the satisfaction survey were not documented and made available to the Council in order to seek their advice regarding the survey. [s. 85. (4) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for the cleaning of the home, including floors and wall surfaces in common areas.

On May 29, 2014 at approximately 11:20 hours, feces were observed on the wall and on the floor in the second shower on the right hand side of the spa room on second floor.

The Environmental Services Manager was present when the observation was made. The Environmental Services Manager stated that feces were present in the shower, and it was the responsibility of the Personal Support Workers to clean the shower chair, walls and floors within the shower after each use.

Interview with Personal Support Worker on second floor stated it was an expectation to clean the shower wall and floor between use with residents. Registered Nurse

confirmed the observation of feces and that Personal Support Workers were supposed to clean the shower after use with each resident. The position summary from the home’s Human Resources Manual -(Index I.D: HRM D-25-25), for Personal Support Workers effective June 19, 2000, revised May 24, 2013, did not state showers were to be cleaned or disinfected between use, however, the home’s orientation for Health Care Aides/Personal Support Workers- (Index I.D: HRM B-35-25), effective June 19, 2000, revised May 24, 2013, included orientation for cleaning and disinfection of shower rooms. [s. 87. (2) (a)]

2. The licensee failed to ensure that procedures were implemented for cleaning and disinfecting of resident care equipment such as tubs, shower chairs and lift chairs. On May 27, 28, 29, 2014, on the third floor spa room, large visible amounts of hair were observed on multiple occasions on the wheels of three commode shower chairs and the tub lift chair was dirty on the surface and underneath the seat.

The home’s policy Specific Orientation Health Care/Aide/Personal Support Worker (Index I.D: HRM B-35-25), revised May 24, 2013, stated that the Personal Support Workers (PSW) were responsible for the cleaning and disinfecting nursing and resident equipment, including shower chairs, tubs and tub lift chairs.

A Personal Support Worker (PSW)stated they were responsible to clean the shower commode chairs, the tub and tub lift chair after every use by a resident. The PSW confirmed that the shower commode chairs did have large clumps of hair in the wheels of three commode shower chairs and that the tub lift chair was dirty and had not been cleaned after it was last used by a resident.

Registered Nursing Staff confirmed that it was the home’s expectation for the PSWs to disinfect and clean all surfaces of the shower chairs, tub and tub lift chairs after every use by a resident. The Registered Nursing Staff confirmed that the equipment was not properly cleaned after it was used by a resident and there were large clumps of hair debris in the shower commode chair wheels and the tub lift chair was dirty both under the seat and on top of the seat surface.[s.87(2) (b)] [s. 87. (2) (b)]

WN #19: 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 failed to ensure that schedules and procedures were in place for routine maintenance of showers in spa rooms as part of the organized program of maintenance services.

On May 27, 28, and 29, 2014, a black discolourant was observed around the base of the walls and in the silicon in both the second and third floor spa rooms.

The Environmental Services Manager and Maintenance staff confirmed presence the black discolourant in the silicon. The Environmental Services Manager stated it had been approximately one year since maintenance was performed for replacement of silicon in the spa rooms, and that there was no routine procedure or schedule in place for maintenance for the silicon in the showers. [s. 90. (1) (b)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L’INSPECTION**	**INSPECTOR ID #/ NO DE L’INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #001	2013_207147_0021	147

Issued on this 2nd day of September, 2014

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

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) :	VALERIE GOLDRUP (539), ASHA SEHGAL (159), DARIA TRZOS (561), DIANNE BARSEVICH (581), LALEH NEWELL (147), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2014_278539_0013
Log No. / Registre no:	H-000556-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 11, 2014
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	COOKSVILLE CARE CENTRE 55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	NICOLE FISHER

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_201167_0013, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that residents are protected from physical abuse by staff members.

Grounds / Motifs :

1. Two previous orders had been served for s.19(1) – Duty to protect on October 9, 2013 during inspection 2013-207147-0020 and on May 8, 2014 during inspection 2104_201167_0013.

In March, 2014, resident #402 reported to their family member that an identified PSW was rough during care. As a result the resident injured their wrist in the process as the PSW "yanked" on the wrist while assisting the resident in bed while providing the resident with continence care.

Interview with resident and review of the home's internal investigation notes indicated that this was the first time this PSW had provided care to the resident and was not aware of the resident's regular routine for continence care while in bed.

The resident's family member reported this allegation of abuse to the Registered Nursing staff at which time an assessment of the affected area was completed by the Registered Staff.

B) The licensee did not ensure that resident #404 was protected from physical abuse by a staff member.

In March, 2014, a nursing student witnessed a PSW forcefully pushing resident #404's head back so that the resident's head hit the back of the wheelchair headrest. Immediately after the witnessed incident the nursing student overheard the resident scream out in pain; as a result of this incident the resident sustained a bruise/hematoma to their head. (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 05, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_189120_0052, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Order / Ordre :

The licensee shall ensure that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c).

Grounds / Motifs :

1. The home (classified as a C home) did not have guaranteed access to a generator that was operational within 3 hours of the power outage that affected the home between 6:15 p.m. on July 8, 2013 and 3:30 a.m. on July 9, 2013 and that could maintain 1) the heating system 2) emergency lighting in hallways, corridors, stairways and exits, 3) essential services including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, 4) the resident-staff communication and response system, 5) elevators, 6) life support and safety and emergency equipment.

The City of Mississauga was affected by a wide area power outage due to a storm beginning at approximately 5:30 p.m July 8, 2013. The home was without power to operate their heating system (if needed), dietary services equipment, resident-staff communication and response system, lighting, elevators, safety and emergency equipment and life support equipment. The home was able to operate some emergency equipment such as the fire panel and alarms and some corridor lighting for approximately 7 hours as they were connected to a battery. According to management staff, 9 residents who were outside of the home or not on their own home floor at the time of the outage became stranded

on the main floor for approximately 8-9 hours. The home's 2 elevators were not functional at the time and could not be used to transport residents back to their rooms. All 9 residents were not able to use the stairs and the home did not have any alternative methods in which to transport them from floor to floor. Residents were therefore accommodated on mattresses which were placed on the floor within the dining room. The home's cold holding equipment was not supplied with any back up power; however, according to the Food Service Manager, the temperature of the refrigerators did not rise high enough to affect perishable foods. None of the meals were affected and residents received their planned menu items.

The home's resident-staff communication and response system was not functional throughout the power outage (8-9 hours). No alternative system was in place other than more frequent monitoring of residents by staff. Therapeutic air surfaces deflated and residents had to be transferred to foam mattresses. Many of the electric beds had to be manually modified. The door locking system which operates on electricity and is on all stairwell and perimeter doors was not functional and had to be manually monitored by staff.

The licensee did not comply with the Order made on August 28, 2013 because the licensee still does not have guaranteed access to a generator that would be operational within three hours of a power outage. The licensee has mitigated some of the risk to residents identified on July 8 and 9, 2013 by entering into an agreement with a generator supplier for access to a generator; however, that access is subject to conditions (generator availability, weather, road conditions). Based on the scope of the non-compliance, the risk to residents should a generator not be operational within three hours of a power outage, and the compliance history, an Order is warranted. Because the licensee now has access to a generator and has indicated its intention to purchase a generator in 2015, the compliance date is set for June 1, 2015. (539)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

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. 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, submit, and implement a plan that outlines how they will ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality, and prepared, stored, and served using methods to prevent adulteration, contamination, and food borne illness.

The plan is to be submitted to Leah.Curle@ontario.ca by September 5, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance, and food quality.

A) During stage 1 of the Resident Quality Inspection, resident #30 stated the home's food quality was not good, and the meat was very dry. Resident #28 reported the meat and fish were a lesser quality, very hard, dry, and tasteless.

B) Prior to the start of lunch service on June 3, 2014, on second floor, pre-portioned bowls of strawberry ice cream were observed on a trolley in the hallway, and appeared half melted. The ice cream bowls were placed in the freezer on a tray during the main course service and removed from the freezer for dessert. Many bowls did not have a visible scoop shape left at the time of service to residents, compromising the appearance of the food. The Food Service Manager stated that new portions of ice cream should have been provided, rather than serving melted ice cream.

C) On June 4, 2014, sweet potato fries were served. During meal service in the first floor dining room, the regular texture sweet potato fries served appeared soggy, compromising the taste and appearance of the food.

D) For the supper meal on June 5, 2014, pork choppettes were on the menu. The Cook reported the product was pre-cooked. Product details stated the pork was a fully cooked pork chop shaped pattie, and contained textured vegetable protein, indicating the meat was processed. The choppettes were cooked almost one hour before served to residents and held in the oven until the meal, which resulted in reduced preservation of taste and appearance. Some of the choppettes appeared overcooked when they were pulled out of the oven. During meal service, the choppette was sampled and was hard on the outside, and spongy on the inside, and did not characterize a texture of pork. (585)

2. The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored, and served using methods to prevent adulteration, contamination, and food borne illness.

A. During supper meal preparation on June 5, 2014, in the kitchen, observed a dietary staff handle raw meat in the sink. After handling the meat, the staff touched a counter surface and fridge handle with their bare hands without washing their hands or cleaning the contaminated surfaces. The dietary staff reported the home's expectation for staff was to wash hands immediately after touching raw meats and touching other surfaces. The Food Service Supervisor confirmed the expectation for staff to wash their hands immediately after touching raw meat before touching other surfaces. The home's Food and Nutritional Services Manual Policy for Safe Food Handling (FNSFS050) stated that staff must wash their hands after handling raw food items.

B. During supper meal preparation June 5, 2014, observed a dietary staff lick their finger and flip pages in the recipe book. The Food Service Supervisor confirmed the expectation for staff to wash their hands immediately after their hands come in contact with their mouth. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2015

Order # / Ordre no : 004

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 prepare, submit and implement a plan that outlines how the home will ensure:
A) that food and fluids being served at a temperature that is both safe and palatable to the residents.
B) that residents are provided with the appropriate any eating aids, assistive devices,
C) personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The plan is to be submitted to Leah.Curle@ontario.ca by September 5, 2014

Grounds / Motifs :

1. The licensee did not ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.
A) Several meal service observations were conducted on all floors during the resident quality inspection. During each meal service, multiple foods were found at unacceptable temperatures at the point of service. The home's temperature record forms stated that cold foods were to be served at 4 degrees Celsius or lower, and hot foods at 60 degrees or higher. The Food Service Supervisor confirmed this expectation.

B) Multiple residents reported that their food was served cold. During stage one of the inspection, Resident #30 reported that sometimes the food was cold, and Resident #28 stated the dinner entrée was sometimes cold. Resident #504 reported that the fries on their room tray service arrived cold on May 30, 2014, and Resident #505 stated the beef was not hot enough during supper on June 5, 2014.

C) The Resident's Council meeting minutes from December, 2013 documented complaints that the French fries were cold. The Food Committee meeting minutes from March, 2014 documented complaints that some foods were not hot enough. (585).

(585)

2. The licensee did not ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The plan of care for resident #101 indicated they were to be provided beverages in a mug with a disposable lid and a straw. During the lunch meal observation on May 26, 2014, the resident received beverages in regular glasses. The resident was observed attempting to drink apple juice independently; the juice was dripping down off the glass.

The plan of care had identified that the resident was to be provided adaptive aides for eating due to tremors as a result of Parkinson condition. The resident was identified to be at risk for choking and swallowing difficulty. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2014

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_207147_0020, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the plan, policy, protocol, procedure, strategy or system for
Nutrition and Hydration
Skin and Wound Care
Bed Rails
is complied with. O. Reg. 79/10, s. 8 (1).

This order was linked with a order from inspection 2013-207147-0020 dated October 9, 2013.

Grounds / Motifs :

1. The licensee did not ensure that the home's Hydration Monitoring policy-(RCS C-40), dated September 4, 2013, was complied with.

A) The home's policy stated the Registered Nursing staff would initiate a dietary referral form for each resident who has not consumed their required amount of fluids for the 24 hour period over a three day time span. An electronic progress note would be included in the resident's chart identifying the section.

The food and fluid intake records for a period of four months, February 2 to May 28, 2014 confirmed resident #14 had consumed less than the established fluid

target of 1530 ml per day each day with an average fluid intake of 1000 ml per day.

A referral to the Registered Dietitian was not initiated when the resident's fluid intake was less than 1000 ml per day for several consecutive days during the months of March, April and May, 2014. Example: April 17, 18, 19, 2014, the resident consumed less than the required amount of fluid for three consecutive days.

A review of clinical health record and interviews with the Registered Dietitian and the Registered Nurse confirmed a referral was not initiated for the resident.

B) The home's policy Recording Food and Fluids Consumed-(FNSCN145),effective March 11, 2014, for monitoring resident's meal, nourishment and supplement intake,stated resident intake of meals, nourishments and supplements shall be monitored and recorded daily. Food and fluid intake must be recorded immediately following consumption of meal. The intake would be documented using paper intake monitoring or electronic.

Resident #14 did not have intake consistently recorded by staff. A review of intake records were found incomplete, several intake entries were missing in the months of February, March, April, and May, 2014. Examples: Resident #14 meal consumption report for a period of four months had 32 meals, snacks, and fluid intake entries not recorded.

The Registered Dietitian confirmed that assessments could not be accurately completed as a result. The Director of Care and the Registered Nurse confirmed the food and fluid intake records were incomplete and the staff had not complied the policy. (159)

2. Review of the home's skin and wound program related to skin tears, that was currently in use, was not in compliance with and was not implemented in accordance with applicable requirement under the Act.

Skin Care and Wound Management program, revised April, 2010 and reviewed on February 3, 2014, did not direct Registered Nursing staff to make a referral to a Registered Dietitian when a resident had a skin tear. The policy stated that a referral to a Registered Dietitian is made for only stage 2, 3, 4, and X wounds.

Registered Nursing staff were not aware that skin tears needed referrals to a Registered Dietitian. Director of Care confirmed that the policy was not updated but staff were aware that all skin tears needed to be referred to a Registered Dietitian.

The licensee did not ensure that where the Act or this Regulation required the licensee to have or put in place any policy, procedure or strategy, that the policy, procedure or strategy was complied with. (561)

3. The home's policy Bed Rails-(Index I.D: RCS E-05),revised August 10, 2013, stated that the interdisciplinary team would reassess the need for bed rails on a quarterly basis at minimum and document this review on the restraint alternative form.

Resident #39 was assessed on August 14, 2013 for the use of bed rails. The assessment indicated that the resident was to have two bed rails raised while in bed as a Personal Assistance Service Device (PASD).

Resident #24 was assessed on August 14, 2013 for the use of bed rails. The assessment indicated that the resident was to have two bed rails raised while in bed as a PASD.

The Director of Care (DOC) confirmed that since the initial bed rail assessment was completed on August 14, 2013, resident #39 and resident #24 were not re-assessed quarterly. DOC also stated the assessment was not documented on the least restraint alternatives assessment form for the use of bed rails as a PASD as required in their bed rails policy. (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 05, 2014

Order # / Ordre no : 006 **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 shall prepare, submit and implement a plan that outlines how the home will ensure that:
a) all menu items are prepared according to the planned menu
b) any menu substitutions are communicated to residents and staff
c) any menu substitutions are documented on the production sheet.

The plan is to be submitted to Leah.Curle@ontario.ca by September 5, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the food production system, at a minimum, provided for preparation of all menu items according to the planned menu.

A) On May 30, 2014, the lunch menu listed low sodium pepper potato soup. The standardized recipe called for 10 ml of white pepper and no salt. During meal production, a Cook was observed pouring white pepper in a #12 scoop, and then added it to the soup. The Cook then partially filled the same #12 scoop with salt and added it to the soup. The Cook confirmed they added salt to the soup.

B) On May 30, 2014, the lunch menu listed fish and chips. The standardized recipe for the puree fish instructed that tartar sauce be added during the puree process. The Dietary staff who pureed the fish stated the puree blend contained only fish and broth.

C) On May 30, 2014, the lunch menu listed fresh diced melon. The standardized recipe called for cantaloupe and honeydew melon. During the lunch meal preparation, a Dietary Aide was observed portioning watermelon in bowls and reported they were portioning six regular texture watermelon for the second floor, and six regular texture watermelon for third floor. The production sheet indicated that 12 regular texture servings of watermelon were to be produced for second floor, and 12 regular texture watermelon servings for the third floor.

D) On June 4, 2014, during lunch preparation, the Cook stated they needed to prepare seven servings of puree soup for the minced and pureed diets for the first floor dining area for residents coming from second and third floor. The production sheet called for nine servings.

E) On June 4, 2014, a Dietary Aide was observed preparing rye turkey sandwiches and was using a #8 scoop for the sandwich filling. The recipe instructed use of a #12 scoop for the filling.

F) On June 5, 2014, a Cook was preparing the pork chopettes for supper. The Cook reported they were going to prepare 71 regular, 31 minced, and 27 pureed texture pork chopettes, five for show plates, and five for extras, totaling to 139 chopettes. The production sheet called for 145 servings. (585)

2. The licensee failed to ensure that the food production system, provided communication to residents and staff of any menu substitutions.

A. On May 30, 2014, the posted daily menu listed croissants for lunch. During meal service, croissants were not served, and instead, dinner rolls were served. The Food Service Supervisor first stated the croissants did not come in, and then later clarified that they forgot to order the croissants. The substitution was not communicated to residents and staff on the posted daily menu. (585)

3. The licensee failed to ensure that the food production system, provided documentation on the production sheets of any menu substitutions.

During the course of the inspection, several menu substitutions were made and substitutions were not documented on the production sheets.

A) On May 26, 2014, white bread was served with the tuna salad plate for lunch meal service on the second floor. The daily menu stated wheat rolls were to be served with the tuna salad plate. The substitution was not documented on the production sheets.

B) On May 30, 2014, a mixture of medallion shaped fries and straight cut fries were prepared and served for lunch. The posted menu called for chips, however the recipe called for straight cut fries. The Food Service Manager confirmed that both forms of fries were served as they decided to use up the rest of the medallion fries from the previous menu cycle. The substitution was not documented on the production sheets.

C) On May 30, 2014, watermelon was prepared and served on all floors in all textures for lunch. The posted menu stated fresh diced melon, however the recipe for the called for cantaloupe and honeydew. The Food Service Supervisor confirmed that the recipe was not followed. The substitution was not documented on the production sheets.

D) On May 30, 2014, puree texture menu listed French fries to be served at lunch. Mashed potatoes were observed to be prepared and served to puree textured diet residents on third floor. The change was not documented on the production sheets.

E) On May 30, 2014, dinner rolls were served with the cottage cheese and fruit plate. The daily menu listed croissants. Following the meal, the Food Service Supervisor stated the croissants never came in, and then later clarified that they forgot to order the croissants. The substitution was not documented on the production sheets.

F) On June 3, 2014, lemon poppy seed bread was served on second floor for lunch. The posted menu listed muffins. The Food Service Supervisor confirmed that they were first made aware the recipe was not followed at the beginning of the lunch. The substitution was not documented on the production sheets.

G) The Food & Nutritional Services policy titled Production Sheets - (FNSFP060), effective January 1, 2011, stated that the Food Services Manager

or Designate was responsible to make changes to the production sheet prior to meal service as required, and cooks were to indicate on the production sheets any overproduction or shortages, and any menu. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2014

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 11th day of August, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Goldrup

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

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 prévue le Loi de 2007 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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Oct 06, 2014;	2014_278539_0013 (A1)	H-000556-14	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5

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

LEAH CURLE (585) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié
Inspection Order Report #2014_278539_0013 has been amended as a result of an entry error on the compliance date. Compliance date for Order #003 has an ammended to November 17, 2014.

Issued on this 6 day of October 2014 (A1)

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

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**Rapport d'inspection prévue le Loi de 2007 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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Oct 06, 2014;	2014_278539_0013 (A1)	H-000556-14	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5

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

LEAH CURLE (585) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 26, 27, 28, 29, 30 and June 3, 4, 5, 6, 9,10, 11, 2014

The following log numbers were completed during this inspection: H-000578-13, H-000359-14, H-000284-14, H-000047-14, H-000316-14, H-000317-14,H-000339-14, H-000052-14, H-000591-14. The following follow-ups were completed during this inspection: H-000651-14, H-000959-13, H-000958-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nurse Clinician, Acting Nurse Manager, Resident Assessment Instrument (RAI) Coordinator, Infection Control Nurse, Skin Care Nurse, Nursing Clerk, Registered Nursing staff including Registered Practical

Nurses (RPN) and Registered Nurses (RN), Personal Support Workers (PSW), Physician, Physiotherapist, Social Service Worker, Registered Dietitian (RD), Food Service Manager, Cook, Dietary Workers/Aides, Environmental Manager, Maintenance staff, Housekeeping staff, Laundry staff, residents and family members of residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed health care records, investigation reports, human resource files, relevant policies, procedures and practices and interviewed staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dining Observation

Family Council

Food Quality

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

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Training and Orientation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. A) The licensee did not ensure that resident #402 was protected from physical abuse by a staff member.

In March, 2014, resident #402 reported to their family that an identified PSW was rough with the resident during care. As a result the resident injured their wrist in the

process as the PSW "yanked" on their wrist while assisting them in bed while providing the resident with continence care.

Interview with resident and review of the home's internal investigation notes indicated that this was the first time this PSW had provided care to the resident and was not aware of the resident's regular routine for continence care while in bed.

The resident's family member reported this allegation of abuse to the Registered Nursing staff at which time an assessment of the affected area was completed by the Registered Staff.

The home notified the Ministry of Health, the Physician and the Police of the alleged incident and submitted a Critical Incident report to the Ministry of Health.

The PSW involved in the incident was terminated after the home's internal investigation was completed.

B) The licensee did not ensure that resident #404 was protected from physical abuse by a staff member.

In March, 2014, a nursing student witnessed a PSW forcefully pushing resident #404's head back so that their head hit the back of the wheelchair headrest. Immediately after the witnessed incident the nursing student overheard the resident scream out in pain; as a result of this incident the resident sustained a bruise/hematoma on their head.

The nursing student reported the witnessed incident to the Registered Nursing staff at which time a head to toe assessment was completed by the Registered Nursing staff. The home removed the PSW from the home pending investigation. The home notified the Ministry of Health, the Physician and the Police and submitted a Critical Incident report to the Ministry of Health.

The PSW involved in the incident was terminated after the home's internal investigation was completed. [s. 19. (1)] (147) [s. 19. (1)]

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. 19. Generators
Specifically failed to comply with the following:

s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Findings/Faits saillants :

1. The home (classified as a C home) did not have guaranteed access to a generator that was operational within 3 hours of the power outage that affected the home between 6:15 p.m. on July 8, 2013 and 3:30 a.m. on July 9, 2013 and that could maintain 1) the heating system 2) emergency lighting in hallways, corridors, stairways and exits, 3) essential services including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, 4) the resident-staff communication and response system, 5) elevators, 6) life support and safety and emergency equipment.

The City of Mississauga was affected by a wide area power outage due to a storm beginning at approximately 5:30 p.m July 8, 2013. The home was without power to operate their heating system (if needed), dietary services equipment, resident-staff communication and response system, lighting, elevators, safety and emergency equipment and life support equipment. The home was able to operate some emergency equipment such as the fire panel and alarms and some corridor lighting for approximately 7 hours as they were connected to a battery. According to management staff, 9 residents who were outside of the home or not on their own home floor at the time of the outage became stranded on the main floor for approximately 8-9 hours. The home's 2 elevators were not functional at the time and could not be used to transport residents back to their rooms. All 9 residents were not able to use the stairs and the home did not have any alternative methods in which to transport them from floor to floor. Residents were therefore accommodated on mattresses which were placed on the floor within the dining room. The home's cold holding equipment was not supplied with any back up power; however, according to the Food Service

Manager, the temperature of the refrigerators did not rise high enough to affect perishable foods. None of the meals were affected and residents received their planned menu items.

The home's resident-staff communication and response system was not functional throughout the power outage (8-9 hours). No alternative system was in place other than more frequent monitoring of residents by staff. Therapeutic air surfaces deflated and residents had to be transferred to foam mattresses. Many of the electric beds had to be manually modified. The door locking system which operates on electricity and is on all stairwell and perimeter doors was not functional and had to be manually monitored by staff.

The licensee did not comply with the Order made on August 28, 2013 because the licensee still does not have guaranteed access to a generator that would be operational within three hours of a power outage. The licensee has mitigated some of the risk to residents identified on July 8 and 9, 2013 by entering into an agreement with a generator supplier for access to a generator; however, that access is subject to conditions (generator availability, weather, road conditions). Based on the scope of the non-compliance, the risk to residents should a generator not be operational within three hours of a power outage, and the compliance history, an Order is warranted. Because the licensee now has access to a generator and has indicated its intention to purchase a generator in 2015, the compliance date is set for June 1, 2015. [s. 19. (4)]

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. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

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 O. Reg. 79/10, s. 72 (3).

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 failed to ensure that the food production system, at a minimum, provided for preparation of all menu items according to the planned menu.

A) On May 30, 2014, the lunch menu listed low sodium pepper potato soup. The standardized recipe called for 10 ml of white pepper and no salt. During meal production, a Cook was observed pouring white pepper in a #12 scoop, and then added it to the soup. The Cook then partially filled the same #12 scoop with salt and added it to the soup. The Cook confirmed they added salt to the soup.

B) On May 30, 2014, the lunch menu listed fish and chips. The standardized recipe for the puree fish instructed that tartar sauce be added during the puree process. The Dietary staff who pureed the fish stated the puree blend contained only fish and broth.

C) On May 30, 2014, the lunch menu listed fresh diced melon. The standardized recipe called for cantaloupe and honeydew melon. During the lunch meal preparation,

a Dietary Aide was observed portioning watermelon in bowls and reported they were portioning six regular texture watermelon for the second floor, and six regular texture watermelon for third floor. The production sheet indicated that 12 regular texture servings of watermelon were to be produced for second floor, and 12 regular texture watermelon servings for the third floor.

D) On June 4, 2014, during lunch preparation, the Cook stated they needed to prepare seven servings of puree soup for the minced and pureed diets for the first floor dining area for residents coming from second and third floor. The production sheet called for nine servings.

E) On June 4, 2014, a Dietary Aide was observed preparing rye turkey sandwiches and was using a #8 scoop for the sandwich filling. The recipe instructed use of a #12 scoop for the filling.

F) On June 5, 2014, a Cook was preparing the pork chopettes for supper. The Cook reported they were going to prepare 71 regular, 31 minced, and 27 pureed texture pork chopettes, five for show plates, and five for extras, totaling to 139 chopettes. The production sheet called for 145 servings. [s. 72. (2) (d)]

2. The licensee failed to ensure that the food production system, provided communication to residents and staff of any menu substitutions.

A)On May 30, 2014, the posted daily menu listed croissants for lunch. During meal service, croissants were not served, and instead, dinner rolls were served. The Food Service Manager first stated the croissants did not come in, and then later clarified that they forgot to order the croissants. The substitution was not communicated to residents and staff on the posted daily menu. [s. 72. (2) (f)]

3. The licensee failed to ensure that the food production system, provided documentation on the production sheets of any menu substitutions.

During the course of the inspection, several menu substitutions were made and substitutions were not documented on the production sheets.

A) On May 26, 2014, white bread was served with the tuna salad plate for lunch meal service on the second floor. The daily menu stated wheat rolls were to be served with the tuna salad plate. The substitution was not documented on the production sheets.

B) On May 30, 2014, a mixture of medallion shaped fries and straight cut fries were prepared and served for lunch. The posted menu called for chips, however the recipe called for straight cut fries. The Food Service Manager confirmed that both forms of fries were served as they decided to use up the rest of the medallion fries from the previous menu cycle. The substitution was not documented on the production sheets.

C) On May 30, 2014, watermelon was prepared and served on all floors in all textures for lunch. The posted menu stated fresh diced melon, however the recipe for the called for cantaloupe and honeydew. The Food Service Supervisor confirmed that the recipe was not followed. The substitution was not documented on the production sheets.

D) On May 30, 2014, puree texture menu listed French fries to be served at lunch. Mashed potatoes were observed to be prepared and served to puree textured diet residents on third floor. The change was not documented on the production sheets.

E) On May 30, 2014, dinner rolls were served with the cottage cheese and fruit plate. The daily menu listed croissants. Following the meal, the Food Service Supervisor stated the croissants never came in, and then later clarified that they forgot to order the croissants. The substitution was not documented on the production sheets.

F) On June 3, 2014, lemon poppy seed bread was served on second floor for lunch. The posted menu listed muffins. The Food Service Supervisor confirmed that they were first made aware the recipe was not followed at the beginning of the lunch. The substitution was not documented on the production sheets.

G) The Food & Nutritional Services policy titled Production Sheets -(FNSFP060), effective January 1, 2011, stated that the Food Services Manager or Designate was responsible to make changes to the production sheet prior to meal service as required, and cooks were to indicate on the production sheets any overproduction or shortages, and any menu substitutions made and for what reason changes were made. [s. 72. (2) (g)]

4. The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance, and food quality.

A) During stage 1 of the Resident Quality Inspection, resident #30 stated the home’s food quality was not good, and the meat was very dry. Resident #28 reported the

meat and fish were a lesser quality, very hard, dry, and tasteless.

B) Prior to the start of lunch service on June 3, 2014, on second floor, pre-portioned bowls of strawberry ice cream were observed on a trolley in the hallway, and appeared half melted. The ice cream bowls were placed in the freezer on a tray during the main course service and removed from the freezer for dessert. Many bowls did not have a visible scoop shape left at the time of service to residents, compromising the appearance of the food. The Food Service Manager stated that new portions of ice cream should have been provided, rather than serving melted ice cream.

C) On June 4, 2014, sweet potato fries were served. During meal service in the first floor dining room, the regular texture sweet potato fries served appeared soggy, compromising the taste and appearance of the food.

D) For the supper meal on June 5, 2014, pork choppettes were on the menu. The Cook reported the product was pre-cooked. Product details stated the pork was a fully cooked pork chop shaped pattie, and contained textured vegetable protein, indicating the meat was processed. The choppettes were cooked almost one hour before served to residents and held in the oven until the meal, which resulted in reduced preservation of taste and appearance. Some of the choppettes appeared overcooked when they were pulled out of the oven. During meal service, the choppette was sampled and was hard on the outside, and spongy on the inside, and did not characterize a texture of pork. [s. 72. (3) (a)]

5. The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored, and served using methods to prevent adulteration, contamination, and food borne illness.

A) During supper meal preparation on June 5, 2014, in the kitchen, observed a Dietary staff handle raw meat in the sink. After handling the meat, the staff touched a counter surface and fridge handle with their bare hands without washing their hands or cleaning the contaminated surfaces.

The Dietary staff reported the home’s expectation for staff was to wash hands immediately after touching raw meats and touching other surfaces. The Food Service Manager confirmed the expectation for staff to wash their hands immediately after touching raw meat before touching other surfaces.

The home’s Food and Nutritional Services Manual Policy for Safe Food Handling-

(FNSFS050), stated that staff must wash their hands after handling raw food items.

B) During supper meal preparation June 5, 2014, observed a Dietary staff lick their finger and flip pages in the recipe book. The Food Service Manager confirmed the expectation for staff to wash their hands immediately after their hands come in contact with their mouth. [s. 72. (3) (b)]

Additional Required Actions:

CO # - 003, 006 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)The following order(s) have been amended:CO# 003

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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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 food and fluids were served at a temperature that was both safe and palatable to the residents.

The temperature record forms at the dining room serveries stated that the temperature expectations were that cold foods were to be served at 4 degrees Celsius or lower, and hot foods be served at 60 degrees Celsius or higher. The Food Service Supervisor confirmed this expectation.(585)

A) Foods were not served at a temperature that was both safe and palatable to the residents at the lunch meal June 3, 2014. Hot food temperatures were tested and recorded during the service and chicken strips were found at 40 degrees Celsius and cubed potatoes at 30 degrees Celsius. The temperature monitoring record indicated that the foods were to be served above 60 degrees Celsius. The hot food was held and served at temperatures that were not safe and palatable. (159)

B) During the lunch meal service on May 30, 2014, on third floor, regular textured potato fries were probed at 48.1 degrees Celsius, regular texture coleslaw at 12.3 degrees Celsius, and minced coleslaw at 10.3 degrees Celsius. Resident # 504 who received tray service reported their fries arrived cold.(585)

C) During lunch meal service on June 4, 2014, on the first floor in the kitchen, regular texture sweet potato fries were recorded at 47.6 degrees Celsius,and minced egg and broccoli frittata were 59 degrees Celsius. Regular texture turkey salad sandwich on white bread was sitting in the middle of the steam table, and was 16 degrees Celsius. (585)

D) During the supper meal service on June 5, 2014, on the third floor, minced steak was 52.6 degrees Celsius, puree steak was 50.6 degrees Celsius, puree pork was 53.9 degrees Celsius, minced peppers and mushrooms were 56 degrees Celsius, puree peppers and mushroom were 49.4 degrees Celsius, and minced herbed potatoes was 55.4 degrees Celsius. Resident #505 stated the beef was not hot enough.(585)

E) During breakfast service on June 6, 2014, on third floor, regular texture fruit was 11.4 degrees Celsius, minced fruit was 15.2 degrees Celsius, and puree fruit was 13.3 degrees Celsius. Regular toast was sitting in the steam table and was 43.7 degrees Celsius.(585)

F) The Resident’s Council meeting minutes in December, 2013 documented complaints that the French fries were cold. The Food Committee meeting minutes from March, 2014 documented complaints that some foods were not hot enough.(585)

G) During the Resident Quality Inspection, resident #30 reported that sometimes the food was cold, and resident #28 stated the dinner entrée was sometimes cold.(585) [s. 73. (1) 6.]

2. The licensee did not ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The plan of care for resident #101 indicated they were to be provided beverages in a mug with a disposable lid and a straw.

During the lunch meal observation on May 26, 2014, the resident received beverages in regular glasses. The resident was observed attempting to drink apple juice independently; the juice was dripping down off the glass.

The plan of care had identified that the resident was to be provided adaptive aides for eating due to tremors as a result of Parkinson condition. The resident was identified to be at risk for choking and swallowing difficulty. [s. 73. (1) 9.]

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 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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Review of the home's skin and wound program related to skin tears, that was currently in use, was not in compliance with and was not implemented in accordance with applicable requirement under the Act.

Skin Care and Wound Management program, revised April, 2010 and reviewed on February 3, 2014, did not direct Registered Nursing staff to make a referral to a Registered Dietitian when a resident had a skin tear. The policy stated that a referral to a Registered Dietitian is made for only stage 2, 3, 4, and X wounds.

Registered Nursing staff were not aware that skin tears needed referrals to a Registered Dietitian. Director of Care confirmed that the policy was not updated but staff were aware that all skin tears needed to be referred to a Registered Dietitian. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee did not ensure that the home's Hydration Monitoring policy-(RCS C-40), dated September 4, 2013, was complied with.

A) The home's policy stated the Registered Nursing staff would initiate a dietary referral form for each resident who has not consumed their required amount of fluids for the 24 hour period over a three day time span. An electronic progress note would be included in the resident's chart identifying the section.

The food and fluid intake records for a period of four months, February 2 to May 28, 2014 confirmed resident #14 had consumed less than the established fluid target of 1530 ml per day each day with an average fluid intake of 1000 ml per day.

A referral to the Registered Dietitian was not initiated when the resident's fluid intake was less than 1000 ml per day for several consecutive days during the months of March, April and May, 2014. Example: April 17, 18, 19, 2014, the resident consumed less than the required amount of fluid for three consecutive days.

A review of clinical health record and interviews with the Registered Dietitian and the Registered Nurse confirmed a referral was not initiated for the resident.

B) The home's policy Recording Food and Fluids Consumed-(FNSCN145),effective March 11, 2014, for monitoring resident's meal, nourishment and supplement intake,stated resident intake of meals, nourishments and supplements shall be monitored and recorded daily. Food and fluid intake must be recorded immediately following consumption of meal. The intake would be documented using paper intake monitoring or electronic.

Resident #14 did not have intake consistently recorded by staff. A review of intake records were found incomplete, several intake entries were missing in the months of February, March, April, and May, 2014. Examples: Resident #14 meal consumption report for a period of four months had 32 meals, snacks, and fluid intake entries not recorded.

The Registered Dietitian confirmed that assessments could not be accurately completed as a result. The Director of Care and the Registered Nurse confirmed the food and fluid intake records were incomplete and the staff had not complied the policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee did not ensure that where the Act or this Regulation required the licensee to have or put in place any policy, procedure or strategy, that the policy, procedure or strategy was complied with.

The home's policy Bed Rails-(Index I.D: RCS E-05),revised August 10, 2013, stated that the interdisciplinary team would reassess the need for bed rails on a quarterly basis at minimum and document this review on the restraint alternative form.

Resident #39 was assessed on August 14, 2013 for the use of bed rails. The assessment indicated that the resident was to have two bed rails raised while in bed as a Personal Assistance Service Device (PASD).

Resident #24 was assessed on August 14, 2013 for the use of bed rails. The assessment indicated that the resident was to have two bed rails raised while in bed as a PASD.

The Director of Care (DOC)confirmed that since the initial bed rail assessment was completed on August 14, 2013, resident #39 and resident #24 were not re-assessed quarterly. DOC also stated the assessment was not documented on the least restraint alternatives assessment form for the use of bed rails as a PASD as required in their bed rails policy. [s. 8. (1) (b)]

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 LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident had the right to be treated with courtesy and respect in a way that fully recognized the resident's individuality and respected the resident's dignity.

On a specific day in June, 2014, at 09:55 hours, observed a resident being wheeled in a beige commode shower chair by a Personal Support Worker into the spa room. The resident was wearing a gown that opened in the back. Between the bottom of the chair back and seat as well as the space below the arm rests and the seat, observed the resident's bare skin exposed, and not wearing briefs. Resident was wheeled in the chair by Personal Support Worker in front of nursing station, in the presence of 14 other residents sitting in the hallway. Personal Support Worker stated resident was toileted in their room before going to the spa room, and the resident was wearing the gown as per their preference, and that the resident also had a shirt on, but they did

not ensure the resident's shirt was pulled down all the way.

Personal Support Worker stated the expectation is to ensure the resident was covered appropriately during the transfer to the spa room. Interview with Registered Nurse confirmed residents being escorted to the spa room are to be covered with a towel if their gown does not cover their body. [s. 3. (1) 1.] (585) [s. 3. (1) 1.]

2. The licensee did not ensure that every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

Resident #200 was admitted to the home in March, 2013. The consent to medical plan of treatment was not signed by the substitute decision maker until May 2, 2013. Resident received treatment in the home without signed consent from March, 2013 until May, 2013.

There was no documentation in progress notes indicating why the family did not sign the consent and registered staff reported that they did not know why the consent was not signed upon admission. [s. 3. (1) 11. ii.]

3. The licensee failed to ensure that the following rights of residents were fully respected and promoted related to every resident has the right to, have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

During medication observation on the 2nd floor on June 4, 2014, while the RPN was assisting residents in the dining room, the Inspector was sitting behind the nursing station and found a wound care supplies requisition sheet dated Nov 20, 2012 in the garbage bin under the nursing station which included names of several residents, including the specific wound care products needed for each resident.

Spoke with the RN on the 2nd floor and the Director of Care (DOC) who both confirmed that this form should have been thrown in the shredder and not in the garbage bin in the nursing station as it contained resident's personal health information. [s. 3. (1) 11. iv.]

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 be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of resident #402’s plan of care last reviewed on May 9, 2014, Resident Assessment Protocol (RAP) summary for the past three quarters (October 7, 2013, January 6 and April 7, 2014) and interview with the Registered Nursing staff indicated the resident required two person total extensive assistance for toileting and bed mobility.

Interview with the resident and review of the home’s internal investigation notes indicated that on March 13, 2014 one PSW provided continence care to the resident while in bed and did not ensure that the care set out in the plan of care was provided to the resident #402 as specified in the plan which resulted in the resident injuring their wrist in the process. [s. 6. (7)]

2. Resident #40 had a coccyx pressure ulcer stage 4 since admission in 2007.

Resident’s plan of care stated the resident was to be turned and repositioned when in bed at least every 2 hours. The resident was to be put back to bed before the end of AM shift and the resident stays in bed till 1130hrs then is up for lunch max 3hrs then is put back to bed.

Resident was observed on June 4, 2014 and was sitting in her wheelchair at 15:45 hours. Interviewed resident and confirmed that staff usually put her back to bed before supper time around 16:30 hours.

Interview with a Personal Support Worker (PSW) that provided direct care to the resident revealed that resident was to be put back to bed before supper time around 16:30 and 17:00 hours. Registered Nursing staff on the evening shift confirmed the same and stated that resident’s care plan was not updated. The nurse confirmed that PSWs that start their shift at 15:00 hours were busy with getting report, doing rounds and taking care of residents’ clothing; therefore resident is put back to bed before supper time.

Reviewed the turning and positioning record and noted that staff had coded on June 3, 2014 that the resident was sitting in their wheelchair for four hours. According to the turning and positioning record for June 12, 2014 the resident had been sitting in their wheelchair since 12:00 hours and was not put back to bed until 16:30 hours.

The Skin Care Nurse confirmed that current care plan directed staff to put resident back to bed at 15:00 hours because they were unable to sit for longer than three hours. Staff did not provide care to the resident as it was specified in the plan of care. [s. 6. (7)]

3. The plan of care for resident #14 indicated resident was to receive high protein high calorie pudding and 250 ml cranberry juice for afternoon snack.

On May 30, 2014, the afternoon snack pass was observed on second floor and a the Personal Support Worker (PSW) served the resident a glass of apple juice and a cookie.

Interview with two PSWs confirmed that there were no labeled special snacks and beverage for the resident, and the resident was served apple juice and a cookie. The diet list/ resident profile information used by the staff personelle did not have the resident's name and special snack listed.

The resident was identified to have a low body mass index and poor oral intake. The care plan for this resident indicated that the resident a required special nourishment, an intervention recommended by the Registered Dietician, for significant unplanned weight loss. Resident observations and staff interviewed confirmed the resident did not receive snacks and beverages as specified in plan. [s. 6. (7)]

4. Resident's plan of care had identified resident was to receive 250 ml lactaid milk at lunch.
The resident was observed in the dining room on May 26, 2014; the resident received 125 ml lactaid milk. The Personal Support Worker (PSW) interviewed reported the special beverages were prepared in the kitchen by the Dietary staff, the resident should have received 250ml lactaid milk. [s. 6. (7)]

5. Resident #500 had a plan of care to follow a gluten free diet as per the resident diet list.

During lunch meal service on May 30, 2014, a Dietary Aide portioned pepper potato soup for resident #500. The therapeutic menu for resident #500 did not list pepper potato soup. The Dietary Aide passed the soup to the Personal Support Worker serving the resident #500. As the Personal Support Worker left the servery to serve the soup, Inspector #585 asked the Dietary Aide if the resident could have the soup. The Dietary Aide consulted with another Dietary staff and determined the soup was not appropriate for resident #500.

The recipe for the pepper potato soup included all-purpose flour. The resident was not served the soup; however the plan of care was not followed as the soup was going to be served to the resident. [s. 6. (7)]

6. Resident #502 had a plan of care to receive double portions of protein at breakfast and lunch. During meal lunch meal service on May 30, 2014, on third floor, a Dietary Aide did not provide resident #502 with double portions of protein. [s. 6. (7)]

7. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) The Minimum Data Set (MDS) assessment for resident #6 dated February 14, 2013, May 13, 2013, August 12, 2013, and November 11, 2013, indicated that the resident had pneumonia.

Progress notes reviewed on May 29, 2014, noted that the resident had pneumonia only during the month of February, 2013. The RAI Coordinator confirmed that resident #6 did not have pneumonia during the months of May, August, and November, 2013 and that Registered Nursing staff did not resolve the infection in the MDS assessment for these months.

B)The MDS assessment for resident #36 dated May 7, 2013, August 5, 2013 and November 4, 2013 specified that resident had pneumonia.

Progress notes and interview with the RAI Coordinator indicated that resident had pneumonia only during the month of May, 2013. For the months of August, and November, 2013. Registered Nursing staff did not resolve the infection in the MDS assessment. [s. 6. (10) (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 be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

Not all residents were served foods that were nutritious and varied.

At the lunch meal on June 3, 2014, the cubed potatoes served were hard and dry and created risk for choking for residents. Numerous residents voiced concerns over the menu and food quality. The Management staff tasted the potatoes and verified the quality of the food served to residents was not acceptable.

During this Resident Quality Inspection interviews with the residents, families and the multiple dining observations the Ministry of Health (MOH) Inspector validated residents' concerns and issues related to food quality, planned menu items not always served, running out of menu items, and unsafe hot food temperatures. [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 , to be implemented voluntarily.

WN #9: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee did not ensure that a Registered Dietitian who was a member of the staff of the home assessed resident #14's hydration status and any risk related to hydration.

The food and fluid intake monitoring record indicated the resident's fluid intake was less than their target fluid requirements. According to the plan of care, their fluid requirements were 1530 ml per day.

The resident had a Nurse Practitioner's order dated April 11, 2014 for "Push Fluids". The food and fluid intake records for a period of four months, February, March, April and May, 2014 were reviewed and identified the resident's fluid intake was most days less than 1000 ml per day. The resident did not meet the fluid requirement of 1530 ml on any day recorded from February to May 29, 2014.

The progress notes dated March 3, 2014, indicated the Registered Dietitian (RD) completed quarterly nutrition assessment, however, the RD did not assess resident's hydration status.

Resident was identified to be at risk of dehydration. On June 3, 2014 the Registered Dietitian interviewed confirmed the resident did not have an interdisciplinary hydration assessment, interventions and strategies had not been initiated to address resident's hydration concerns. [s. 26. (4) (a),s. 26. (4) (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 be implemented voluntarily.

WN #10: 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. The licensee did not ensure that resident #14, with the weight changes, was assessed using an interdisciplinary approach and action taken and outcomes were evaluated.

Resident #14 had a significant weight loss of 10.5 per cent over six months from November, 2013 to May, 2014. Progress notes dated March 3, 2014 and May 15, 2014 indicated referrals were initiated related to diet change, weight loss and the resident's return from hospitalization.

The dietary referral response nutrition notes documented by the Registered Dietitian (RD)on March 3, 2014, stated "resident is not meeting estimated nutritional requirements with current intake. Resident has lost weight which is undesirable. Current Body Mass Index (BMI) 19.1, resident remains high nutrition risk". The dietary summary completed on May 15, 2104, by the RD stated resident had further lost weight in the past two months, the weight loss was due to change in intake. However,the review by the RD did not include an assessment of the resident in relation to weight loss and poor food intake. The plan was to continue with current nutrition interventions, which were not effective to address the ongoing poor intake and unplanned weight loss.

A significant weight change i.e weight loss, and poor oral intake were not reassessed using an interdisciplinary approach and outcomes evaluated to address the noted nutritional concerns. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 be implemented voluntarily.

WN #11: 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 the planned menu items were offered and available at each meal and snack.

A)On May 26, 2014 the planned menu posted for lunch consisted of carrot orange soup, tuna and salad plate, wheat roll and pineapple slices. An alternate choice menu was peameal bacon on bun, creamy coleslaw and pumpkin custard.(159)

Residents were not served wheat roll as part of the tune salad plate. Residents were served tossed salad instead of coleslaw with peameal bacon on bun.(159)

The Dietary Aide reported they did not have rolls, and instead, had white and brown bread. (585)

The Cook reported residents were provided tossed salad as they ran out of coleslaw. The coleslaw shortage was not communicated to the residents.(159)

On May 26, 2014 during lunch on the second floor, observed and confirmed with the Dietary Aide they ran out of regular and minced coleslaw, and regular peameal bacon. (585)

Residents voiced their concerns regarding the planned menu not always served, menu substitutions were frequently made, not communicated and also running out of food.(159)

B) On May 30, 2014, the lunch menu for gluten restricted/minced meat diet included gluten free whole grain bread as a second option.

During lunch on the third floor, the Dietary Aide stated there was no grain or starch available to serve the resident. The resident was served non-breaded fish and coleslaw.
Following the meal, the Food Service Manager reported and showed that gluten free bread and buns were available in the kitchen.

C) On May 30, 2014, the lunch menu for the vegetarian diet included options of a vegetarian quesadilla or a cottage cheese and fruit plate. During lunch on the third floor, the Dietary Aide stated the only meal choice for vegetarians was the quesadilla. The vegetarian residents were not offered all planned menu items. The quesadilla and cottage cheese and fruit plate were available at the time of service.

D) On May 30, 2014, the lunch menu stated croissants were to be served with the cottage cheese plate.During the lunch meal on the third floor, croissants were not available for meal service, and instead, dinner rolls were served.The Food Service Manager stated they forgot to order the croissants.

E) On June 5, 2014, the supper menu for vegetarian diet included vegetarian meat balls and vegetarian beef strips. During supper meal service on third floor, vegetarian meatballs were observed as the only option available for vegetarian residents.The Dietary Aide confirmed the only entree available for vegetarian residents at the time of service was vegetarian meatballs.

F) On June 5, 2014, the supper gluten free menu included gluten free bread. During supper meal service on third floor, gluten free bread was brought up from the kitchen to the floor at 17:50 hours, 20 minutes after meal service started. The home's Food & Nutritional Services policy titled Planned Menu Choices Will Be Prepared at the Same Time-(FNSMS090), effective January 1, 2011, stated that all menu choices for all therapeutic and texture modified diets, should be prepared, provided, and available and ready to be served at the same time for all diet types.

G) During every dining observation conducted during the inspection, staff ran out of

food at meal service. On May 30, 2014 during lunch on the third floor, observed and confirmed with the Dietary Aide that they ran out of minced fish. On June 3, 2014 during lunch on the second floor, the Dietary Aide reported to be short of two servings of minced chicken.
On June 4, 2014 during lunch on the first floor in the kitchen servery, observed and confirmed with kitchen staff that they were short five turkey sandwiches, one serving of minced egg frittata, and regular texture beets. On June 5, 2014 during supper on the third floor, observed and confirmed with the Dietary Aide that they ran out of puree bread. On June 6, 2014 during breakfast on the third floor, the Dietary Aide ran out three servings of regular texture fruit. (585) [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 be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

The home's policy-(Index I.D:ES-D-20-30), related to Personal Clothing Procedures for the Lost/Unclaimed Clothing stated all lost clothing concerns of families or visitors were brought to the Resident Services Coordinator or delegate. The Resident Service Coordinator would complete a client service response or complete a missing clothing checklist and forward the response to the nursing and laundry departments. The policy also stated the nursing department would search the home area and the laundry department would search for the missing clothing and report back to the Resident Service Coordinator. The Resident Services Coordinator would report the results back to the family or visitors that made the complaint.

Resident #1, #10, #39, #100 and families who were interviewed stated they had reported missing clothing and personal items to the Management staff. A review of the progress notes for identified residents verified the Registered Nursing staff had documented missing clothing and personal items reported by the residents and the families.

Interviews with the Registered Nursing staff and the Resident Care Co-ordinator/Social Worker confirmed they had not completed a client service response or missing clothing checklist for identified residents.

On May 30, 2014 during the interview with Laundry staff, it was confirmed that they were not aware of any formal process for notification of laundry or tracking of lost items provided for Laundry staff to use. They also indicated that staff would usually verbally tell them when something was missing or family members would come to the laundry and report lost items to them. They would then look in closets and the laundry area to try to find the lost item. They were not aware of any formal process for the documentation of missing items or the results of search.

Residents and the families interviewed confirmed lost clothing and personal items were still missing. The home had not notified them of tracking of lost laundry and personal items or the results of the search.

The procedure for missing clothing and management of personal belonging was not followed and communicated to the resident/ substitute decision maker/family. [s. 89. (1) (a) (iv)]

2. Resident #503 reported to have missing laundry in 2012, and stated they reported it to staff. Review of progress notes stated resident reported missing clothes in September, 2012. The Administrator reported that an initial client services response form should have been completed. The home’s policy titled Personal Clothing Procedures, Storage of Lost/Unclaimed Personal Clothing-(Index I.D: ES D-20-30), revised February 1, 2012, stated that the expectation was for staff to complete a missing clothing checklist. The missing clothing checklist was not completed for the resident’s missing clothing, and a client services response form was not completed after review of complaint and concerns log. (585) [s. 89. (1) (a) (iv)]

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 be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the Infection Prevention and Control program.

On May 30, 2014, at 11:45 hours, a PSW was observed walking out of a resident's room with gloves on, holding dirty linen They put it in the dirty linen hamper out in the hallway, took their gloves off, took clean towels and proceeded to go into resident's room #328 to assist another resident. PSW never washed or sanitized hands after taking gloves off.

The Policy related to infection prevention and control-(Index I.D: IFC B-15), Routine Practices, revised August 10, 2013, reviewed February 2014, stated that "gloves do not provide the user with total protection from sources of contamination. Consequently, hands must be washed immediately after removal of gloves."

Hand Hygiene Audits were performed in the home every month using the Observation Tool by the Infection Control Nurse. The Observation Tools were reviewed for the months of March, April and May 2014 and revealed that staff that were audited did not perform "4 moments of hand hygiene". [s. 229. (4)]

2. During breakfast meal service on June 6 2014, on the third floor, a Personal Support Worker was observed feeding resident #500. The Personal Support Worker then went to another table to assist resident #501 and was observed holding the resident's fork and touching the resident's arm. The Personal Support Worker then returned to resident #500 and wiped resident's nose and face with a napkin without washing or sanitizing their hands between the resident interactions.

The home Hand Hygiene Program policy-(Index I.D: IPC H-15), original date January 21, 2010, revised August 10, 2013, identified that staff were to complete hand hygiene before initial contact with a resident, and after contact with a resident or items in their immediate surroundings. [s. 229. (4)]

3. On June 3, 2014, during lunch on second floor, a Personal Support Worker was observed transferring an over-bed table from room 233 to resident #507's room as resident #507 required tray service and did not have their own over-bed table. The table was visibly soiled with dried fluid and crumbs. The Personal Support Worker was observed wiping the over-bed table with hand sanitizer and paper towel, then transferred the table to resident #507's room.

The Personal Support Worker reported that the home's expectation was to use Virox wipes but they did not have any nearby so they used the sanitizer. A Registered Nursing Staff confirmed the home's expectation was to use sanitary wipes if sharing a

over-bed table between residents. The Personal Support Worker/Health Care Aide position summary in the Human Resources Manual (Index I. D: HRM D-25-25), revised May 24, 2013, stated that Personal Support Workers/Health Care Aides were responsible to follow disinfection protocols to minimize the spread of infection. The home's policy for Infection Prevention and Control-(IFC B-15), titled Routine Practices, original dated January 30, 2004, revised May 3, 2010, also stated that reusable equipment that had been in direct contact with the resident should be cleaned before use in care with another resident for items that are in touch with intact skin, and equipment that was visibly soiled should be cleaned. [s. 229. (4)]

4. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Resident #200 was admitted to the home on March 26, 2013. According to progress notes the resident did not receive TB screening until May 13, 2013. Infection Control Nurse confirmed that the resident should have had the screening done within 14 days of admission to the home. [s. 229. (10) 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 be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that 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.

Review of the home's Abuse or Neglect Policy -(Index ID - A-10), last revised date of April 29, 2011, indicated that the person first having knowledge of when a resident is suspected of abuse or neglect shall immediately inform the Administrator, or if not available the Director of Nursing/or Delegate.

Review of resident #402's clinical chart, home's internal investigation notes and interview with the resident confirmed that on March 13, 2014 a PSW handled the resident roughly while providing care to the resident while in bed. This resulted in the resident hurting their wrist due to being grabbed roughly by the PSW during care. However, the PSW involved in the incident did not report this to the Charge Nurse on the unit, even though the resident did verbalize pain during and after the incident and that there was a verbal altercation between the PSW and the resident during care. The incident was shared by the resident to their family member the following day which was then reported to the Charge Nurse. [s. 20. (1)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure the use of the Personal Assistance Service Device (PASD) had been consented to by the resident or, if the resident is incapable, a substitute decision maker of the resident with authority to give that consent.

Reviewed the plan of care and Resident #24 was assessed on August 14, 2013, for the use of two bed rails raised as a PASD when in bed. Consent was not signed by the resident's substitute decision maker until March 19, 2014.

Reviewed the plan of care and Resident #39 was assessed on August 14, 2013, for the use of two bed rails raised as a PASD when in bed. Consent was not signed by the resident's substitute decision maker until January 16, 2014

Interviewed Registered Nursing staff and they confirmed that consent was not signed for two bed rails to be raised as a PASD at the time of the initial assessment and application of the raised rails. [s. 33. (4) 4.]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee did not ensured that the home convened semi-annual meetings to advise to such persons of the rights to establish a Family Council.

A review of the Family Council meeting minutes confirmed the last Family Council meeting was convened on May 29, 2012. Interviews with the Administrator and the Social Worker confirmed the Family Council was not established, and the home had not convened semi-annual meetings. [s. 59. (7) (b)]

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

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. The licensee did not seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results.

The President of the Residents' Council interviewed stated the Residents' Council had not participated in developing and carrying out the satisfaction survey. This information was verified by the Administrator.

Interviews with the Council Assistant and a review of Residents' Council meeting minutes from 2013 and 2014 confirmed that the advice of the Council was not sought regarding the satisfaction survey specifically related to its development, implementation and in acting on the results. [s. 85. (3)]

2. The licensee did not ensure the results of the survey were documented and made available to the Residents' Council in order to seek their advice regarding the survey.

Interview with the President of Residents' Council, the Council Assistant, the Administrator and the review of meeting minutes for 2013 and 2014 confirmed that the results of the satisfaction survey were not documented and made available to the Council in order to seek their advice regarding the survey. [s. 85. (4) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for the cleaning of the home, including floors and wall surfaces in common areas.

On May 29, 2014 at approximately 11:20 hours, feces were observed on the wall and on the floor in the second shower on the right hand side of the spa room on second floor.

The Environmental Services Manager was present when the observation was made. The Environmental Services Manager stated that feces were present in the shower, and it was the responsibility of the Personal Support Workers to clean the shower chair, walls and floors within the shower after each use.

Interview with Personal Support Worker on second floor stated it was an expectation to clean the shower wall and floor between use with residents. Registered Nurse confirmed the observation of feces and that Personal Support Workers were

supposed to clean the shower after use with each resident. The position summary from the home's Human Resources Manual -(Index I.D: HRM D-25-25), for Personal Support Workers effective June 19, 2000, revised May 24, 2013, did not state showers were to be cleaned or disinfected between use, however, the home's orientation for Health Care Aides/Personal Support Workers- (Index I.D: HRM B-35-25), effective June 19, 2000, revised May 24, 2013, included orientation for cleaning and disinfection of shower rooms. [s. 87. (2) (a)]

2. The licensee failed to ensure that procedures were implemented for cleaning and disinfecting of resident care equipment such as tubs, shower chairs and lift chairs. On May 27, 28, 29, 2014, on the third floor spa room, large visible amounts of hair were observed on multiple occasions on the wheels of three commode shower chairs and the tub lift chair was dirty on the surface and underneath the seat.

The home's policy Specific Orientation Health Care/Aide/Personal Support Worker (Index I.D: HRM B-35-25), revised May 24, 2013, stated that the Personal Support Workers (PSW) were responsible for the cleaning and disinfecting nursing and resident equipment, including shower chairs, tubs and tub lift chairs.

A Personal Support Worker (PSW)stated they were responsible to clean the shower commode chairs, the tub and tub lift chair after every use by a resident. The PSW confirmed that the shower commode chairs did have large clumps of hair in the wheels of three commode shower chairs and that the tub lift chair was dirty and had not been cleaned after it was last used by a resident.

Registered Nursing Staff confirmed that it was the home's expectation for the PSWs to disinfect and clean all surfaces of the shower chairs, tub and tub lift chairs after every use by a resident. The Registered Nursing Staff confirmed that the equipment was not properly cleaned after it was used by a resident and there were large clumps of hair debris in the shower commode chair wheels and the tub lift chair was dirty both under the seat and on top of the seat surface.[s.87(2) (b)] [s. 87. (2) (b)]

WN #19: 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 failed to ensure that schedules and procedures were in place for routine maintenance of showers in spa rooms as part of the organized program of maintenance services.

On May 27, 28, and 29, 2014, a black discolourant was observed around the base of the walls and in the silicon in both the second and third floor spa rooms.

The Environmental Services Manager and Maintenance staff confirmed presence the black discolourant in the silicon. The Environmental Services Manager stated it had been approximately one year since maintenance was performed for replacement of silicon in the spa rooms, and that there was no routine procedure or schedule in place for maintenance for the silicon in the showers. [s. 90. (1) (b)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L’INSPECTION**	**INSPECTOR ID #/ NO DE L’INSPECTEUR**
LTCHA, 2007 s. 23. (1)	CO #001	2013_207147_0021	147

Issued on this 6 day of October 2014 (A1)

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Hamilton Service Area Office
119 King Street West, 11th Floor
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LEAH CURLE (585) - (A1)
Inspection No. / No de l'inspection :	2014_278539_0013 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	H-000556-14 (A1)
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 06, 2014;(A1)
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	COOKSVILLE CARE CENTRE 55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : NICOLE FISHER

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_201167_0013, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that residents are protected from physical abuse by staff members.

Grounds / Motifs :

1. Two previous orders had been served for s.19(1) – Duty to protect on October 9, 2013 during inspection 2013-207147-0020 and on May 8, 2014 during inspection 2104_201167_0013.

In March, 2014, resident #402 reported to their family member that an identified PSW was rough during care. As a result the resident injured their wrist in the process as the PSW "yanked" on the wrist while assisting the resident in bed while providing the resident with continence care.

Interview with resident and review of the home's internal investigation notes indicated that this was the first time this PSW had provided care to the resident and was not aware of the resident's regular routine for continence care while in bed.

The resident's family member reported this allegation of abuse to the Registered Nursing staff at which time an assessment of the affected area was completed by the Registered Staff.

B) The licensee did not ensure that resident #404 was protected from physical abuse by a staff member.

In March, 2014, a nursing student witnessed a PSW forcefully pushing resident #404's head back so that the resident's head hit the back of the wheelchair headrest. Immediately after the witnessed incident the nursing student overheard the resident scream out in pain; as a result of this incident the resident sustained a bruise/hematoma to their head. (147)

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

Sep 05, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_189120_0052, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Order / Ordre :

The licensee shall ensure that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c).

Grounds / Motifs :

1. The home (classified as a C home) did not have guaranteed access to a generator that was operational within 3 hours of the power outage that affected the home between 6:15 p.m. on July 8, 2013 and 3:30 a.m. on July 9, 2013 and that could maintain 1) the heating system 2) emergency lighting in hallways, corridors, stairways and exits, 3) essential services including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, 4) the resident-staff communication and response system, 5) elevators, 6) life support and safety and emergency equipment.

The City of Mississauga was affected by a wide area power outage due to a storm beginning at approximately 5:30 p.m July 8, 2013. The home was without power to operate their heating system (if needed), dietary services equipment, resident-staff communication and response system, lighting, elevators, safety and emergency equipment and life support equipment. The home was able to operate some

emergency equipment such as the fire panel and alarms and some corridor lighting for approximately 7 hours as they were connected to a battery. According to management staff, 9 residents who were outside of the home or not on their own home floor at the time of the outage became stranded on the main floor for approximately 8-9 hours. The home's 2 elevators were not functional at the time and could not be used to transport residents back to their rooms. All 9 residents were not able to use the stairs and the home did not have any alternative methods in which to transport them from floor to floor. Residents were therefore accommodated on mattresses which were placed on the floor within the dining room. The home's cold holding equipment was not supplied with any back up power; however, according to the Food Service Manager, the temperature of the refrigerators did not rise high enough to affect perishable foods. None of the meals were affected and residents received their planned menu items.

The home's resident-staff communication and response system was not functional throughout the power outage (8-9 hours). No alternative system was in place other than more frequent monitoring of residents by staff. Therapeutic air surfaces deflated and residents had to be transferred to foam mattresses. Many of the electric beds had to be manually modified. The door locking system which operates on electricity and is on all stairwell and perimeter doors was not functional and had to be manually monitored by staff.

The licensee did not comply with the Order made on August 28, 2013 because the licensee still does not have guaranteed access to a generator that would be operational within three hours of a power outage. The licensee has mitigated some of the risk to residents identified on July 8 and 9, 2013 by entering into an agreement with a generator supplier for access to a generator; however, that access is subject to conditions (generator availability, weather, road conditions). Based on the scope of the non-compliance, the risk to residents should a generator not be operational within three hours of a power outage, and the compliance history, an Order is warranted. Because the licensee now has access to a generator and has indicated its intention to purchase a generator in 2015, the compliance date is set for June 1, 2015. (539)

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

Jun 01, 2015

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. 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, submit, and implement a plan that outlines how they will ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality, and prepared, stored, and served using methods to prevent adulteration, contamination, and food borne illness.

The plan is to be submitted to Leah.Curle@ontario.ca by September 5, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance, and food quality.

A) During stage 1 of the Resident Quality Inspection, resident #30 stated the home's food quality was not good, and the meat was very dry. Resident #28 reported the meat and fish were a lesser quality, very hard, dry, and tasteless.

B) Prior to the start of lunch service on June 3, 2014, on second floor, pre-portioned bowls of strawberry ice cream were observed on a trolley in the hallway, and appeared half melted. The ice cream bowls were placed in the freezer on a tray during the main course service and removed from the freezer for dessert. Many bowls did not have a visible scoop shape left at the time of service to residents, compromising the appearance of the food. The Food Service Manager stated that new portions of ice cream should have been provided, rather than serving melted ice cream.

C) On June 4, 2014, sweet potato fries were served. During meal service in the first floor dining room, the regular texture sweet potato fries served appeared soggy, compromising the taste and appearance of the food.

D) For the supper meal on June 5, 2014, pork choppettes were on the menu. The Cook reported the product was pre-cooked. Product details stated the pork was a fully cooked pork chop shaped pattie, and contained textured vegetable protein, indicating the meat was processed. The choppettes were cooked almost one hour before served to residents and held in the oven until the meal, which resulted in reduced preservation of taste and appearance. Some of the choppettes appeared overcooked when they were pulled out of the oven. During meal service, the choppette was sampled and was hard on the outside, and spongy on the inside, and did not characterize a texture of pork. (585)

2. The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored, and served using methods to prevent adulteration, contamination, and food borne illness.

A. During supper meal preparation on June 5, 2014, in the kitchen, observed a dietary staff handle raw meat in the sink. After handling the meat, the staff touched a counter surface and fridge handle with their bare hands without washing their hands or cleaning the contaminated surfaces. The dietary staff reported the home’s expectation for staff was to wash hands immediately after touching raw meats and touching other surfaces. The Food Service Supervisor confirmed the expectation for staff to wash their hands immediately after touching raw meat before touching other surfaces. The home’s Food and Nutritional Services Manual Policy for Safe Food Handling (FNSFS050) stated that staff must wash their hands after handling raw food items.

B. During supper meal preparation June 5, 2014, observed a dietary staff lick their finger and flip pages in the recipe book. The Food Service Supervisor confirmed the expectation for staff to wash their hands immediately after their hands come in contact with their mouth. (585)

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

Nov 17, 2014(A1)

Order # /
Ordre no : 004

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 prepare, submit and implement a plan that outlines how the
home will ensure:
A) that food and fluids being served at a temperature that is both safe and palatable to the residents.
B) that residents are provided with the appropriate any eating aids, assistive devices,
C) personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The plan is to be submitted to Leah.Curle@ontario.ca by September 5, 2014

Grounds / Motifs :

1. The licensee did not ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.
A) Several meal service observations were conducted on all floors during the resident quality inspection. During each meal service, multiple foods were found at unacceptable temperatures at the point of service. The home’s temperature record forms stated that cold foods were to be served at 4 degrees Celsius or lower, and hot foods at 60 degrees or higher. The Food Service Supervisor confirmed this expectation.

B) Multiple residents reported that their food was served cold. During stage one of the inspection, Resident #30 reported that sometimes the food was cold, and Resident #28 stated the dinner entrée was sometimes cold. Resident #504 reported that the fries on their room tray service arrived cold on May 30, 2014, and Resident #505 stated the beef was not hot enough during supper on June 5, 2014.

C) The Resident’s Council meeting minutes from December, 2013 documented complaints that the French fries were cold. The Food Committee meeting minutes from March, 2014 documented complaints that some foods were not hot enough. (585).

(585)

2. The licensee did not ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The plan of care for resident #101 indicated they were to be provided beverages in a mug with a disposable lid and a straw. During the lunch meal observation on May 26, 2014, the resident received beverages in regular glasses. The resident was observed attempting to drink apple juice independently; the juice was dripping down off the glass.

The plan of care had identified that the resident was to be provided adaptive aides for eating due to tremors as a result of Parkinson condition. The resident was identified to be at risk for choking and swallowing difficulty. (159)

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

Nov 17, 2014

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2013_207147_0020, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the plan, policy, protocol, procedure, strategy or system for
Nutrition and Hydration
Skin and Wound Care
Bed Rails
is complied with. O. Reg. 79/10, s. 8 (1).

This order was linked with a order from inspection 2013-207147-0020 dated October 9, 2013.

Grounds / Motifs :

1. The licensee did not ensure that the home's Hydration Monitoring policy-(RCS C-40), dated September 4, 2013, was complied with.

A) The home's policy stated the Registered Nursing staff would initiate a dietary referral form for each resident who has not consumed their required amount of fluids for the 24 hour period over a three day time span. An electronic progress note would be included in the resident's chart identifying the section.

The food and fluid intake records for a period of four months, February 2 to May 28, 2014 confirmed resident #14 had consumed less than the established fluid target of 1530 ml per day each day with an average fluid intake of 1000 ml per day.

A referral to the Registered Dietitian was not initiated when the resident's fluid intake was less than 1000 ml per day for several consecutive days during the months of March, April and May, 2014. Example: April 17, 18, 19, 2014, the resident consumed less than the required amount of fluid for three consecutive days.

A review of clinical health record and interviews with the Registered Dietitian and the Registered Nurse confirmed a referral was not initiated for the resident.

B) The home's policy Recording Food and Fluids Consumed-(FNSCN145),effective March 11, 2014, for monitoring resident's meal, nourishment and supplement intake,stated resident intake of meals, nourishments and supplements shall be monitored and recorded daily. Food and fluid intake must be recorded immediately following consumption of meal. The intake would be documented using paper intake monitoring or electronic.

Resident #14 did not have intake consistently recorded by staff. A review of intake records were found incomplete, several intake entries were missing in the months of February, March, April, and May, 2014. Examples: Resident #14 meal consumption report for a period of four months had 32 meals, snacks, and fluid intake entries not recorded.

The Registered Dietitian confirmed that assessments could not be accurately completed as a result. The Director of Care and the Registered Nurse confirmed the food and fluid intake records were incomplete and the staff had not complied the policy. (159)

2. Review of the home's skin and wound program related to skin tears, that was currently in use, was not in compliance with and was not implemented in accordance with applicable requirement under the Act.

Skin Care and Wound Management program, revised April, 2010 and reviewed on February 3, 2014, did not direct Registered Nursing staff to make a referral to a Registered Dietitian when a resident had a skin tear. The policy stated that a referral to a Registered Dietitian is made for only stage 2, 3, 4, and X wounds.

Registered Nursing staff were not aware that skin tears needed referrals to a Registered Dietitian. Director of Care confirmed that the policy was not updated but staff were aware that all skin tears needed to be referred to a Registered Dietitian.

The licensee did not ensure that where the Act or this Regulation required the licensee to have or put in place any policy, procedure or strategy, that the policy, procedure or strategy was complied with. (561)

3. The home's policy Bed Rails-(Index I.D: RCS E-05),revised August 10, 2013, stated that the interdisciplinary team would reassess the need for bed rails on a quarterly basis at minimum and document this review on the restraint alternative form.

Resident #39 was assessed on August 14, 2013 for the use of bed rails. The assessment indicated that the resident was to have two bed rails raised while in bed as a Personal Assistance Service Device (PASD).

Resident #24 was assessed on August 14, 2013 for the use of bed rails. The assessment indicated that the resident was to have two bed rails raised while in bed as a PASD.

The Director of Care (DOC) confirmed that since the initial bed rail assessment was completed on August 14, 2013, resident #39 and resident #24 were not re-assessed quarterly. DOC also stated the assessment was not documented on the least restraint alternatives assessment form for the use of bed rails as a PASD as required in their bed rails policy. (581)

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

Sep 05, 2014

Order # / Ordre no : 006

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 shall prepare, submit and implement a plan that outlines how the home will ensure that:
a) all menu items are prepared according to the planned menu
b) any menu substitutions are communicated to residents and staff
c) any menu substitutions are documented on the production sheet.

The plan is to be submitted to Leah.Curle@ontario.ca by September 5, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the food production system, at a minimum, provided for preparation of all menu items according to the planned menu.

A) On May 30, 2014, the lunch menu listed low sodium pepper potato soup. The standardized recipe called for 10 ml of white pepper and no salt. During meal production, a Cook was observed pouring white pepper in a #12 scoop, and then added it to the soup. The Cook then partially filled the same #12 scoop with salt and added it to the soup. The Cook confirmed they added salt to the soup.

B) On May 30, 2014, the lunch menu listed fish and chips. The standardized recipe for the puree fish instructed that tartar sauce be added during the puree process. The Dietary staff who pureed the fish stated the puree blend contained only fish and broth.

C) On May 30, 2014, the lunch menu listed fresh diced melon. The standardized recipe called for cantaloupe and honeydew melon. During the lunch meal preparation, a Dietary Aide was observed portioning watermelon in bowls and reported they were portioning six regular texture watermelon for the second floor, and six regular texture watermelon for third floor. The production sheet indicated that 12 regular texture servings of watermelon were to be produced for second floor, and 12 regular texture watermelon servings for the third floor.

D) On June 4, 2014, during lunch preparation, the Cook stated they needed to prepare seven servings of puree soup for the minced and pureed diets for the first floor dining area for residents coming from second and third floor. The production sheet called for nine servings.

E) On June 4, 2014, a Dietary Aide was observed preparing rye turkey sandwiches and was using a #8 scoop for the sandwich filling. The recipe instructed use of a #12 scoop for the filling.

F) On June 5, 2014, a Cook was preparing the pork chopettes for supper. The Cook reported they were going to prepare 71 regular, 31 minced, and 27 pureed texture pork chopettes, five for show plates, and five for extras, totaling to 139 chopettes. The production sheet called for 145 servings. (585)

2. The licensee failed to ensure that the food production system, provided communication to residents and staff of any menu substitutions.

A. On May 30, 2014, the posted daily menu listed croissants for lunch. During meal service, croissants were not served, and instead, dinner rolls were served. The Food Service Supervisor first stated the croissants did not come in, and then later clarified that they forgot to order the croissants. The substitution was not communicated to residents and staff on the posted daily menu. (585)

3. The licensee failed to ensure that the food production system, provided documentation on the production sheets of any menu substitutions.

During the course of the inspection, several menu substitutions were made and substitutions were not documented on the production sheets.

A) On May 26, 2014, white bread was served with the tuna salad plate for lunch meal service on the second floor. The daily menu stated wheat rolls were to be served with the tuna salad plate. The substitution was not documented on the production sheets.

B) On May 30, 2014, a mixture of medallion shaped fries and straight cut fries were prepared and served for lunch. The posted menu called for chips, however the recipe called for straight cut fries. The Food Service Manager confirmed that both forms of fries were served as they decided to use up the rest of the medallion fries from the previous menu cycle. The substitution was not documented on the production sheets.

C) On May 30, 2014, watermelon was prepared and served on all floors in all textures for lunch. The posted menu stated fresh diced melon, however the recipe for the called for cantaloupe and honeydew. The Food Service Supervisor confirmed that the recipe was not followed. The substitution was not documented on the production sheets.

D) On May 30, 2014, puree texture menu listed French fries to be served at lunch. Mashed potatoes were observed to be prepared and served to puree textured diet residents on third floor. The change was not documented on the production sheets.

E) On May 30, 2014, dinner rolls were served with the cottage cheese and fruit plate. The daily menu listed croissants. Following the meal, the Food Service Supervisor stated the croissants never came in, and then later clarified that they forgot to order the croissants. The substitution was not documented on the production sheets.

F) On June 3, 2014, lemon poppy seed bread was served on second floor for lunch. The posted menu listed muffins. The Food Service Supervisor confirmed that they were first made aware the recipe was not followed at the beginning of the lunch. The substitution was not documented on the production sheets.

G) The Food & Nutritional Services policy titled Production Sheets -(FNSFP060), effective January 1, 2011, stated that the Food Services Manager or Designate was responsible to make changes to the production sheet prior to meal service as required, and cooks were to indicate on the production sheets any overproduction or shortages, and any menu. (585)

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

Nov 17, 2014

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
Toronto ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 6 day of October 2014 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : LEAH CURLE - (A1)

Service Area Office / Bureau régional de services : Hamilton