Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 22, 2016	2016_283544_0001	029394-15	Resident Quality Inspection

Licensee/Titulaire de permis

NORTH CENTENNIAL MANOR INC.
2 Kimberly Drive KAPUSKASING ON P5N 1L5

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

NORTH CENTENNIAL MANOR
2 KIMBERLY DRIVE KAPUSKASING ON P5N 1L5

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

FRANCA MCMILLAN (544), MARIE LAFRAMBOISE (628), SYLVIE BYRNES (627)

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): January 4, 5, 6, 7, 2016 and included three other logs. The logs were related to the follow up of a Compliance order, a Critical Incident (CI) related to an alleged staff to resident abuse and a CI related to a disease outbreak.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care (ADOC), Acting Food Service Manager (AFSM), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Activity Co-ordinator, Personal Support Workers (PSWs), Residents and Families.

The inspectors also toured the home daily, observed staff to resident interactions, staff providing care to residents, meal services, snack services, reviewed residents' health care records, residents' plans of care and the home's policies relevant to this inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Trust Accounts

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

9 WN(s)
6 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 241. (6)	CO #001	2015_380593_0003	544

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**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. (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 79/10, s. 72 (4).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's food production system, at a minimum, provided for production sheets for all menus.

Inspector # 544 reviewed the home's Dietary Services Menu Planning Policy, DSM 03-10 -03 and the current menus. The Inspector identified that the home did not use and did not have any form of production sheets available. There was no documentation to support an organized food production system that included the number of servings to prepare according to diet and diet textures, shortages of food produced and over production of menu items.

In an interview with the Inspector, the Administrator, S # 125 and S # 114 all confirmed that the home did not have any production sheets. The Administrator contacted another member of the multidisciplinary team and informed the Inspector that production sheets were not used and that information was communicated verbally as required. The Administrator told the Inspector that there was no documentation to support that the

home had implemented production sheets and that production sheets should have been implemented. [s. 72. (2) (c)]

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

The Inspector reviewed the planned weekly dinner menu that was posted. The menu indicated that the residents were to be served veal scaloppini with mashed potatoes. The alternative was chicken and vegetable stew with a dinner roll. The daily menu posted in the dining room for the residents, indicated that the residents were served barbecued pork ribs, paprika potatoes, parsley carrots and a raisin butter tart. The alternative menu items that were served, were chicken, buttered egg noodles, sauteed cabbage and fresh watermelon.

The Inspector reviewed the planned weekly lunch menu that was posted outside the dining room and identified that the residents were to be served beef barley soup, vegetable rice frittata, a baked tomato, a scone and a cherry tart. The alternative meal was V8 juice, seafood salad and a fresh fruit cup. The daily menu, that was posted for the residents in the dining room, identified that the residents were served beef barley soup, herbed omelette, mashed potatoes, peas and carrots and a cherry tart. The alternative menu items that were served, were V 8 juice, seafood salad and a fresh fruit cup.

The Inspector interviewed the Administrator, S # 114 and S # 125 who all told the inspector that the planned weekly menu items and the daily menu items were often changed. The home's food production system did not provide for the production of menu items according to the planned menu. [s. 72. (2) (d)]

3. The licensee has failed to ensure that the home's food production system, at a minimum, included communication to residents and staff of any menu substitutions.

The Inspector interviewed residents # 001, # 006, # 008, # 009, # 010 and # 011 who were entering the dining room for meals. They were asked by the Inspector how the menu changes were communicated to them. They told the Inspector that the menu changes were not communicated to them. The residents told the Inspector that they would come to the dining room and they would look at the daily menu for that specific meal and then choose their meal.

The Inspector interviewed PSW # 107, # 108, #109 and PSW # 110 who served the meals. They all told the Inspector that the menu changes were communicated to the residents only at the time of the meal, when the staff were retrieving the show plates to assist the residents with their meal choice. [s. 72. (2) (f)]

4. The licensee has failed to ensure that the home's food production system, at a minimum included documentation, on the production sheets, of any menu substitutions.

The Inspector reviewed the home's Dietary Services Menu Planning Policy, DSM 03-10-03 and the planned menus. The Inspector identified that the home did not use or have any type of production sheets.

In an interview with the Inspector, the Administrator, S # 114 and S # 125 all confirmed that the home did not have or use production sheets. The Administrator told the Inspector that there was no documentation to support that the home had implemented production sheets and that production sheets should have been implemented. Therefore, documentation of the menu substitutions did not occur. [s. 72. (2) (g)]

5. The licensee did not maintain and keep for at least one year, a record of, menu substitutions.

The Inspector identified that there was no documentation or records kept of menu substitutions.

In an interview with the Inspector, the Administrator, S # 114, S # 125 and a member of the multidisciplinary team all confirmed that there were no records kept of menu substitutions. They all confirmed that records from the dietary department were often placed in the shredding box and not kept and that any communication was verbal from a member of the multidisciplinary team to the other staff members. The Administrator, S # 114, S # 125 and another member of the multidisciplinary team stated that they were not aware that these records had to be maintained and kept for one year. [s. 72. (4) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 maintain and keep, for at least one year, a record of menu substitutions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector reviewed a Critical Incident related to resident # 005 being improperly transferred.

According to the Critical Incident (CI) report, PSW # 104 was transferring resident # 005 back to their bed alone and did not use a transferring device. Resident # 005 sustained an injury to their body.

Inspector reviewed resident # 005's plan of care and mobility assessment and identified that resident # 005 required a transferring device and the assistance of two staff members for all transfers.

Inspector interviewed PSW # 104 who told the Inspector that they did not follow resident # 005's plan of care and thus the injury occurred during an unsafe transfer.

Inspector interviewed the Administrator who told the Inspector that PSW # 104 stated that they had completed an unsafe transfer. PSW # 104 did not provide care as specified in resident # 005's plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care for resident # 005 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

Inspector reviewed a Critical Incident related to the transferring of resident # 005.

According to the Critical Incident report, PSW # 104 was transferring resident # 005 back to their bed alone and did not use a transferring device. Resident # 005 sustained an injury to their body.

Inspector reviewed resident # 005's plan of care which identified that resident # 005 was to be transferred using a transferring device, assisted by two staff members, for all transfers.

Inspector reviewed resident # 005's mobility assessment that also identified that resident # 005 required a two person transfer and a transferring device.

Inspector interviewed PSW # 104 who told the Inspector that they transferred resident # 005 alone, without a transferring device and did not have another staff member assist them.

Inspector interviewed the Administrator who told the Inspector that PSW # 104 stated that they had completed this unsafe transfer. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning techniques when assisting resident # 005 and all residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviors.

Inspector # 627 reviewed resident # 001's progress notes which identified that resident # 001 exhibited aggressive verbal responsive behaviors towards other residents and staff.

Inspector reviewed resident # 001's plan of care and identified that there were no strategies to respond to resident # 001's responsive behaviors.

In an interview with the Inspector, RN # 113 confirmed that resident # 001 frequently became upset and exhibited responsive behaviours. RN # 113 also confirmed that resident # 001's responsive behaviors were not addressed in the plan of care and should have been. [s. 53. (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 ensure that strategies are developed and implemented to respond to the needs of residents demonstrating responsive behaviors, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration programs included the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition and dietary services and hydration.

Inspector observed three snack passes and identified that there were no sheets or documentation on the cart to ensure that the PSW staff, distributing the snacks, were aware of residents' diets, special needs and preferences.

Inspector interviewed RN # 102 who told the Inspector that a new process was implemented whereby, PSW staff were to bring with them, when distributing snacks, an i Pad where they were to verify the resident's diet and document the resident's intake at the time of the snack distribution. RN # 102 confirmed that this was not being done and the PSWs relied on their memory. RN # 102 confirmed that there were no policies and procedures related to nutrition and dietary services and hydration as yet.

PSW # 120, # 121, # 122, # 123 and PSW # 124 all told the Inspector that they relied on their memory in distributing the snacks and after the snack pass, they documented the resident's intake via their i Pad. These staff members were not aware of any policies and/or procedures, that were developed, relating to nutrition and dietary services and hydration.

The Administrator and a member of the multidisciplinary team told the Inspector that there were sheets, in the resident's home area, that staff used, that identified the resident's name, diet, likes and dislikes but did not include their fluid texture. These sheets were not titled, not kept and were placed in the shredding box after the meal. These sheets were not used for snack passes. They confirmed that there were no policies or procedures as to how these sheets were to be implemented.

The Administrator and the Inspector reviewed the home's Dietary Policy and Procedure binder and confirmed that the nutrition care and hydration program policies and procedures were not developed and implemented in regards to nutrition care and hydration. The Administrator told the Inspector that all the policies were being reviewed and revised and this had not yet been completed. [s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition care and hydration programs include the development and implementation, in consultation with a registered dietitian, who is a member of the staff of the home, of policies and procedures relating to nutrition and dietary services and hydration, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle included menus for regular, therapeutic and texture modified diets for both meals and snacks.

Inspector # 628 interviewed resident # 012 who told the Inspector that the food served seemed to be the same food served week after week and that there was not much variation between the weekly menu cycles.

Inspector # 544 interviewed resident # 009 who told the Inspector that the food was "so so" and had not changed in many years and that the food was the same all the time.

Inspector # 544 reviewed the planned weekly posted menu cycle for Week 2 posted in the Sunrise/Morning Dove dining room. The menu cycle was identified as FS 2010 Week 2. This weekly menu only identified the regular diet menu.

The Inspector also reviewed the planned weekly posted menu cycle for Week 2 posted in the Kitchen and Snowy Owl/ Sunset dining room. The menu cycle was identified as FS

2009 Week 2. This weekly menu only identified the regular diet menu.

The Inspector interviewed the S # 114 and S # 125 who told the Inspector that for texture, diabetic and other modified diets, S # 114 and S # 125 puree or mince the food for those residents who require that texture, diabetics receive ½ portions of the dessert and residents on a weight reduction program were served smaller portions of the menu items. These guidelines were given to them by a member of the multidisciplinary team and these were the guidelines they followed. [s. 71. (1) (b)]

2. The licensee failed to ensure that the home's menu cycle included menus for regular, therapeutic and texture modified diets for both meals and snacks.

Inspector observed three snack passes whereby the snack cart contained many varieties of cookies and juices that the residents could choose from.

In an interview, S # 114 and S # 125 told the Inspector that there were no menus for regular, therapeutic and modified diets for snacks. This was also confirmed by the Administrator.

PSW # 120, # 121 and PSW # 122 told the Inspector that residents had a wide variety of choices for snacks and fluids however, there was no menu cycle for snacks. The snack cart always contained the same variety of cookies and fluids.

The Administrator, S # 125 and S # 114 all told the Inspector that the home did not have a menu cycle for snacks that included regular, therapeutic and texture modified diets.

The Inspector interviewed a member of the multidisciplinary team who told the inspector that the full menu had not been changed for five years. There were no Spring/Summer menus or Fall/Winter menus as there was in the past. The multidisciplinary team member had been in the home for a short period of time and the home had made only slight changes to the menu items, throughout the year, which they approved. The multidisciplinary team member confirmed that the menus posted were outdated and only identified the regular diet menu plan. [s. 71. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu cycle includes menus for regular, therapeutic and textured modified diets for both meals and snacks, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Administrator and other staff of the home attended Resident's Council meetings only when invited.

In an interview with the Inspector, resident #116 confirmed that the Administrator and other staff members, of the home, attended every Resident Council meeting without being invited. Resident #116 told the Inspector that the Administrator thought this was a requirement.

In an interview with the Inspector, the Administrator confirmed that they attended each Resident Council meetings which facilitated communication.

Inspector # 627 reviewed the Resident Council meeting minutes and noted that three staff members had attended two monthly meetings. Four staff had attended another monthly meeting and five staff had attended a subsequent monthly meeting. The staff had not been invited to these Resident Council meetings.
[s. 64.]

WN #8: 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: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

Inspector observed a dinner dining service in two of the home's dining rooms. The Inspector observed that some residents had their dessert on the table while they were still eating their main course.

Inspector interviewed PSW # 107 and PSW # 108, PSW # 109 and PSW # 110 who told the Inspector that the expectation was that the meals were to be served course by course by staff. They also told the Inspector that some staff, who help with the meal service, often will serve the main course and the dessert course, to the residents, at the same time. This was confirmed by RN # 102.

Inspector interviewed the Administrator and S # 125 who confirmed that the meal service was to be delivered course by course and that this was not followed. [s. 73. (1) (8)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed immediately, in as much detail as is possible, in the circumstances, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Inspector reviewed a Critical Incident report related to an outbreak of a reportable disease.

The home did not immediately report this disease outbreak to the Director.

The Inspector interviewed the Administrator and a member of the multidisciplinary team who confirmed that this was correct. [s. 107. (1) (5)]

Issued on this 2nd day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FRANCA MCMILLAN (544), MARIE LAFRAMBOISE (628), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2016_283544_0001
Log No. / Registre no:	029394-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 22, 2016
Licensee / Titulaire de permis :	NORTH CENTENNIAL MANOR INC. 2 Kimberly Drive, KAPUSKASING, ON, P5N-1L5
LTC Home / Foyer de SLD :	NORTH CENTENNIAL MANOR 2 KIMBERLY DRIVE, KAPUSKASING, ON, P5N-1L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Claude Tremblay

To NORTH CENTENNIAL MANOR INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

1. The licensee shall review and revise the home's current food production system to ensure the following:
a) that production sheets are developed and implemented for all menus

b) that the preparation of all menu items is done according to the planned menu

c) that there is a system of communication to residents and staff of any menu substitutions

d) that there is documentation, on the production sheets, of any menu substitutions.

2. The licensee shall provide training for all dietary staff on the revised food production system.

3. The licensee shall develop a monitoring system to identify problems with the food production system so that corrections can be made.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's food production system, at a minimum, provided for production sheets for all menus.

Inspector # 544 reviewed the home's Dietary Services Menu Planning Policy, DSM 03-10-03 and the current menus. The Inspector identified that the home did not use and did not have any form of production sheets available. There was no documentation to support an organized food production system that included the number of servings to prepare according to diet and diet textures, shortages of food produced and over production of menu items.

In an interview with the Inspector, the Administrator, S # 125 and S # 114 all confirmed that the home did not have any production sheets. The Administrator contacted another member of the multidisciplinary team and informed the Inspector that production sheets were not used and that information was communicated verbally as required. The Administrator told the Inspector that there was no documentation to support that the home had implemented production sheets and that production sheets should have been implemented. (544)

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

The Inspector reviewed the planned weekly dinner menu that was posted. The menu indicated that the residents were to be served veal scaloppini with mashed potatoes. The alternative was chicken and vegetable stew with a dinner roll. The daily menu posted in the dining room for the residents, indicated that the residents were served barbecued pork ribs, paprika potatoes, parsley carrots and a raisin butter tart. The alternative menu items that were served, were chicken, buttered egg noodles, sauteed cabbage and fresh watermelon.

The Inspector reviewed the planned weekly lunch menu that was posted outside the dining room and identified that the residents were to be served beef barley soup, vegetable rice frittata, a baked tomato, a scone and a cherry tart. The alternative meal was V8 juice, seafood salad and a fresh fruit cup. The daily menu, that was posted for the residents in the dining room, identified that the residents were served beef barley soup, herbed omelette, mashed potatoes,

peas and carrots and a cherry tart. The alternative menu items that were served, were V 8 juice, seafood salad and a fresh fruit cup.

The Inspector interviewed the Administrator, S # 114 and S # 125 who all told the inspector that the planned weekly menu items and the daily menu items were often changed. The home's food production system did not provide for the production of menu items according to the planned menu. (544)

3. The licensee has failed to ensure that the home's food production system, at a minimum, included communication to residents and staff of any menu substitutions.

The Inspector interviewed residents # 001, # 006, # 008, # 009, # 010 and # 011 who were entering the dining room for meals. They were asked by the Inspector how the menu changes were being communicated to them. They told the Inspector that the menu changes were not communicated to them. The residents told the Inspector that they would come to the dining room and they would look at the daily menu for that specific meal and then choose their meal.

The Inspector interviewed PSW # 107, # 108, #109 and PSW # 110 who served the meals. They all told the Inspector that the menu changes were communicated to the residents only at the time of the meal, when the staff were retrieving the show plates to assist the residents with their meal choice. (544)

4. The licensee has failed to ensure that the home's food production system, at a minimum included documentation, on the production sheets, of any menu substitutions.

The Inspector reviewed the home's Dietary Services Menu Planning Policy, DSM 03-10-03 and the planned menus. The Inspector identified that the home did not use or have any type of production sheets.

In an interview with the Inspector, the Administrator, S # 114 and S # 125 all confirmed that the home did not have or use production sheets. The Administrator told the Inspector that there was no documentation to support that the home had implemented production sheets and that production sheets should have been implemented. Therefore, documentation of the menu substitutions did not occur. (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2016

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 22nd day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Franca McMillan

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