Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2014	2014_210169_0012	H-000641-14	Resident Quality Inspection

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - TULLAMORE
133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3

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

YVONNE WALTON (169), DARIA TRZOS (561), DIANNE BARSEVICH (581), IRENE PASEL (510), LALEH NEWELL (147), PHYLLIS HILTZ-BONTJE (129), VIKTORIA SHIHAB (584)

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): June 4, 5, 6, 9, 10, 11, 12, 13, 2014

The following complaints were inspected with this inspection: H-000341-13, H-00197-14, H-000452-13, H-000196-14 and H-000551-13., H-000667-14 YW

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Admission Coordinator, Director of Dietary Services, Food Services Supervisor, Dietitian, RAI Coordinator, Director of Resident Programs, Associate Director of Cares, Environmental Services Manager, Registered Nursing staff, Personal Support Workers, Dietary Aides, housekeeping staff, Residents and Families.

During the course of the inspection, the inspector(s) observed all clinical areas, conducted clinical reviews (including retrospective clinical reviews), reviewed policies and procedures and minutes of meetings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).

Review of the homes complaint log revealed a written complaint was received by the home. A review of the Ministry of Health and Long Term Care (MOHLTC) Critical Incident System revealed no report was received regarding the alleged abuse. A review of the homes critical incident (CI) log in June, 2014 revealed no record of a CI submission. The Executive Director confirmed the allegation of patient neglect had not been reported immediately to the Director. [s. 24. (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 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 alternatives to the use of a PASD (personal assistive safety device) 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. Resident #8, 9 and #15 were observed using bed rails to assist them with transferring and bed mobility, however the licensee did not ensure alternatives have been considered. The Registered Nursing staff and Director of Care confirmed this. [s. 33. (4) 1.]

2. The licensee did not ensure that the use of the PASD for Resident #8, #9 and #15 were approved by, any person provided for in the regulations.
Clinical documentation for these residents was reviewed and there were no documented approvals for the use of the PASD. The Registered Nursing staff and Director of Care confirmed there were no approvals for the use of the PASD's. [s. 33. (4) 3.]

3. The licensee did not ensure that the use of the PASD was consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM)of the resident with authority to give consent. Resident #8, #9 and #15, or their SDM did not provide consent to use the PASD/bed rails. The clinical documentation, Registered Staff and Director of Care confirmed this. [s. 33. (4) 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. 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 where the Act or this Regulation requires the licensee to have or put in place any policy, procedure or strategy, that the policy, procedure or strategy was complied with.

The licensee did not ensure that the policy named "Falls Prevention" #V3-630 and revised on November, 2013 was complied with. The policy stated that all residents will be assessed by nursing and/or physiotherapy for risk of falls on admission, quarterly, during a significant change in status and post fall. Resident #202 fell and sustained an injiry. Review of the clinical record indicated that the resident was not assessed for risk of fall quarterly, during a significant change and post fall. The registered staff confirmed that the falls risk assessments were not completed for Resident #202 as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee did not ensure that the policy named "Restrain and PASD Mechanical" V3-1340 was complied with for Resident #8, #9 and #15. The policy directs the staff to review, reassess, and evaluate resident use of PASD monthly, annually evaluate the use of PASD's including an evaluation of what changes and improvements are required and to document on each resident using a PASD the following: 1. Evidence of providing care as set out in the plan of care. 2 The expected outcomes in the plan of care and 3. The evidence of the effectiveness and evaluation that the plan of care is effective. The policy also directs staff to document:
A. assessment and alternatives evaluation of PASD.
B. authorization/prescribing orders
D. consent for PASD
E. application of PASD and manufacturers specifications

The Director of Care and documentation confirmed this was not completed for Resident #8, #9 and #15. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee did not ensure that the policy named "Lost/Missing Clothing" #V8-300 was complied with. The policy directs that if staff are unable to find the missing items, a lost/missing articles form would be completed and a search for the missing item initiated. The Director of Care confirmed the policy applies to lost clothing and lost property. A review of progress notes for Resident #274 reported a missing item in May, 2014. There was a second notation date of June, 2014 that stated the family called again inquiring about the status of the lost irem. The Program Manager confirmed that they received a note from staff in June, 2014 that advised her the

family had called again in June, 2014. A search for the item found nothing. A review of the lost/missing article log did not identify the missing item. [s. 8. (1) (b)]

4. The licensee did not ensure that the policy named "Responsive Behaviour Management" #V3-092 was complied with.
The policy directed that a management strategy for responsive resident behaviour include the assessment and identification of behavioural triggers where possible. Documentation in Resident #304's clinical record in the Point of Care (POC) indicated that the resident demonstrated wandering behaviour eight times over a four week period of time. Clinical documentation and the Director of Resident Care confirmed that there was not an attempt to identify possible triggers for this new responsive behaviour being demonstrated by the resident. [s. 8. (1) (b)]

5. The licensee did not ensure that the policy named "Abuse and Neglect" #V3-010 was complied with.
The policy directs the charge nurse in the home to immediately report any improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. The policy requires immediate reporting to the Ministry of Health and Long Term Care (MOHLTC) Director by initiating a mandatory Critical Incident System (CIS)report. Contact information for business hours and for after hours contact is provided in the policy . A formal complaint of patient neglect was received by the home. The written follow up letter from the Director of Care (DOC) to the family (complainant) indicated a copy of the response was sent to the MOHLTC. A review of the MOHLTC case notes log determined there was no record of this Critical Incident being reported to the MOHLTC. The Executive Director confirmed the alleged /neglect was not reported immediately as required by the homes policy. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure Resident #4, #7 and #9 were assessed and their bed systems evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the residents.
On June 10 and 11, 2014 all three residents were observed with side rails in the up position while in bed. The clinical documentation was reviewed and there were no assessments completed for the use of the bed rail or of their bed systems, to minimize risks to the residents.
Interview with the physiotherapy staff, nursing staff and the Director of Care confirmed there wasn't an assessment completed. [s. 15. (1) (a)]

2. The licensee did not ensure that where bed rails were used in the home that safety issues related to the use of bed rails were addressed, in relation to the following: [15(1)(c)]
The licensee did not ensure that bed rails being used for Resident #001 and Resident #015 were properly secured to the bed frames.
In June, 2014 it was noted that the quarter rail attached to Resident #001's bed was loose and could be moved away from the mattress leaving a four and one half inch gap between the mattress and the bed rail.

The Director of Care confirmed that this has been an ongoing issued and is caused by the bolt that secures the bed rail to the bed frame becoming loose. [s. 15. (1) (c)]

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. 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 did not ensure that staff used safe transferring and positioning devices or techniques when assisting residents, in relation to the following; [s.36]
In February, 2014, while being transferred by two Personal Support Workers (PSW) with a mechanical lift, resident #212 fell and sustained an injury. The equipment used for this lift was checked by the manufacturer and was not identified as a contributing factor to the fall. Interviews with PSW and Registered staff confirmed the resident did fall while being transferred by the mechanical lift but they could not identify the contributing factors that caused the fall. The staff did not ensure that safe transferring techniques were used when assisting resident #212. [s. 36.] [s. 36.]

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. 6. Plan of care

Specifically failed to comply with the following:

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

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of Resident #3 so that their assessments are integrated, consistent with and complement each other.

A clinical record review and staff interviews confirmed that Resident #3 did not receive a nutritional supplement prescribed. Registered Dietitian (RD) nutritional assessments in October 2013, January, 2014 and March, 2014 were based on the RD's understanding that the resident was receiving the supplement as ordered. The RD confirmed that she did not receive a referral to indicate that the resident was not receiving supplementation and did not verify intake with nurses prior to completing the assessments. Nurses verified that the supplement order was not processed in a manner that allowed staff to track intake. The resident's full time nurse was not aware of the order. The resident's last three quarterly assessments were based on inaccurate nutritional intake data. [s. 6. (4) (a)]

2. The licensee did not ensure that care set out in the plan of care was provided to Resident #3 as specified in the plan.

Clinical records for Resident #3 indicated that the resident was at high nutritional risk with suboptimal nutritional intake requiring nutritional supplementation. The resident had a history of low body weight. In September, 2013, based on Registered Dietitian (RD) recommendations, a physician's order was placed for Resource three times daily. The supplement order was included on the January, 2014 and March, 2014 Physician's Order Reviews. No documentation was found to verify that the resident received the prescribed supplement. Interviews with the resident's full time nurse, Charge nurse and Director of Care confirmed the Resident was not provided with the supplement.

3. The licensee did not ensure that Resident #008 was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective, in relation to the following:

Clinical information collected during Minimum Data Set (MDS) reviews completed in January, 2014 and April, 2014 indicated that the care being provided to Resident #008 had not been effective in reaching the care goals established for this resident and the resident plan of care was not reviewed or revised over this period of time.

The document used in the home to provide care directions for staff providing care was not revised following this review when it was identified that the care being provided to the resident had not been effective in meeting the goals of care established.

Additional Required Actions:

CO # - 006 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 that ensures the staff and others involved in the different aspects of care of all residents collaborate with each other in the assessment of the residents so that their assessments are integrated and are consistent with and complement each other and also ensures that all residents are reassessed and their plans of care reviewed and revised when care set out in the plan has not been effective, to be implemented voluntarily.

WN #7: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that Resident #401 was properly fed in a manner consistent with the resident's needs.

Resident #401 was observed to consume a tray lunch in the resident's room. During interviews, the resident confirmed they had not been able to eat in the dining room due to a high level of noise and inappropriate resident behaviours (arguments, shouting and profanity). Observations of the dining room during breakfast and lunch service confirmed a significant level of noise and resident responsive behaviours. The Food Committee minutes for the January 28 and February 18, 2014 meetings confirmed resident concerns regarding too much noise in the dining room during meal service. Resident #401 confirmed their current meal options were limited because hot foods and fluids usually arrived cold and unappetizing. The resident confirmed they would prefer to eat meals in the dining room should the atmosphere improve. [s. 3. (1) 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 that ensures residents rights are fully respected and promoted (4) and every resident is properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure that Resident #13 and Resident #8 were bathed by the method of his or her choice, including tub baths, showers, and full body sponge baths.

Resident #13 and Resident #8 indicated during interviews that they have not been offered a choice of bath since admission. Both resident's verbalized they did not know that having a bath was an option. On June 6, 2014 a Personal Support Worker (PSW) on the resident's home area confirmed that residents get a shower twice weekly and do not get baths. Inspector met with an Assistant Director of Care (ADOC) and both residents to discuss findings. Both residents confirmed their preference for having a bath as part of their personal care routine to the ADOC. [s. 33. (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 that ensures all residents are bathed by a method of his or her choice, including tub baths, showers, and full body sponge baths, to be implemented voluntarily.

WN #9: 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 did not ensure that behavioural triggers where identified for responsive behaviours being demonstrated by Resident #304, in relation to the following:
Clinical documentation included in the Point of Care (POC) flow sheet indicated that Resident #304 was demonstrating behaviours. Staff documented that this behaviour was demonstrated in May and June, 2013. At the time of this inspection where was no evidence in the clinical record that there had been an attempt to identify the possible triggers for this behaviour. The DRC confirmed that there had not been an assessment completed to identify possible behavioural triggers for this behaviour being demonstrated. [s. 53. (4) (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 that ensures that, for each resident demonstrating responsive behaviours, the behavioural triggers for the residents are identified, where possible, to be implemented voluntarily.

WN #10: 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:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that foods and fluids are served to all residents at a temperature that is safe and palatable.

During interviews on June 4 and June 5, 2014 four residents indicated that foods were not served at appropriate temperatures. Resident #401 receives tray meal service; the resident stated that soups and entrees were always cold. Resident #13 indicated that all hot items (soup, tea and coffee) were always lukewarm and the ice cream sometimes served melted. Resident #8 indicated that hot items such as soup, coffee, tea and vegetables were often served cold. A review of the Food Committee minutes revealed ongoing resident complaints regarding food temperatures at the October 15, 2013, January 8, 2014 and February 18, 2014 meetings: liquefied ice cream, cold entrees, cold vegetables and frozen berries unthawed in desserts. Inspector observed lukewarm soup being served to Resident #400 and Resident #401 at lunch observation. [s. 73. (1) 6.]

2. The licensee did not ensure that sufficient time was provided for Resident #400 to eat at their own pace.

In June, 2014 Resident #400 was observed during lunch service in the dining room. The entree was served to the resident at 12:32pm. At time of entree service the resident's soup was also on the table and has not yet been offered to the resident. A Personal Support Worker (PSW) was observed feeding the resident the soup and entree from 12:32 to 12:49pm, in 17 minutes. The feeding was too rapid for the resident's ability to swallow, evidenced by incomplete clearing between bites. The resident did not have the opportunity to complete the meal. An interview with the PSW confirmed that dining service was often rushed, with insufficient time for residents to eat at their own pace. A review of the Food Committee minutes for the August 20, 2013 meeting confirmed residents' concerns regarding feeling rushed during meals. [s. 73. (1) 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 that ensures that the home has a dining and snack service that includes, at a minimum, food and fluids being served at a temperature that is both safe and palatable to the residents and sufficient time for every resident to eat at his or her own pace, is provided, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

Resident #3 was observed on June 6 and 12, 2014 to have dirty fingernails on both hands. Review of the home's flow sheet and interview with the Registered staff indicated that the resident had consistently refused nail care since November 2013 and that no further interventions and strategies were in place to ensure that the resident's fingernails were cut and cleaned. (147) [s. 35. (2)]

WN #12: 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).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

A review of the Residents' Council minutes for June 18, 2013 to May 20, 2014 revealed no documentation of member input into the development and carrying out of the satisfaction survey. An interview with the Residents' Council Liaison and the Residents' Council President confirmed that the council members were not asked for their input prior to the development and carrying out of the survey. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were stored in an area or a medication cart that was secure and locked, in relation to the following: Staff did not ensure that drugs were stored in an area or medication cart that was secured and locked while administering medications on June 12, 2014. At 0915hrs a Registered practical nurse (RPN) was noted to prepare crushed medication in applesauce, leave this medication container on the top of the medication cart and then leave the vicinity of the medication cart to respond to a nurse call bell. At the time it was noted that residents were in the hallway of this home area and could have accessed these medications. [s. 129. (1) (a) (ii)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the annual evaluation of the training and orientation program was evaluated and updated in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices, in relation to the following:

The Administrator confirmed that the process used in the home to evaluate the training and orientation program was not based on evidenced-based practices or prevailing practices. The annual evaluation of this program provided by the home at the time of this inspection included education provided in 2013, but does not evaluate the effectiveness of training approaches used or the quality care outcomes gained following training.
(PLEASE NOTE: The above evidence was identified while inspecting Complaint Log #H-000551-13) [s. 216. (2)]

WN #15: 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).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the infection prevention and control program, in relation to the following:
Staff did not follow infection prevention and control practices when on June 10, 2014 it was noted that a urine collection container was stored on the back of the toilet and a urine collection bag with uncapped tubing was wrapped in a towel and stored on a resident mobility device in washroom. This washroom was shared by two residents.
Staff did not follow infection prevention and control practices when on June 10, 2014 it was noted that a urinal was stored on the back of the toilet, a urinal was stored on the counter beside the sink, a urine collection container was stored on the back of the toilet, an uncapped urine collection bag was hung on the grab bar at the back of the toilet and the commode that was placed over the toilet was soiled with a brown substance. At the time of this inspection this room was shared by two residents.
The Director of Resident Care confirmed that staff had not followed the infection control practices expected in the home when these articles were stored in resident washrooms and directed staff in the appropriate storage of this equipment. [s. 229. (4)]

Issued on this 7th day of July, 2014

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

Yvonne Walton

Ontario

Ministry of Health and Long-Term Care

Ministére 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

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) :	YVONNE WALTON (169), DARIA TRZOS (561), DIANNE BARSEVICH (581), IRENE PASEL (510), LALEH NEWELL (147), PHYLLIS HILTZ-BONTJE (129), VIKTORIA SHIHAB (584)
Inspection No. / No de l'inspection :	2014_210169_0012
Log No. / Registre no:	H-000641-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 7, 2014
Licensee / Titulaire de permis :	VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - TULLAMORE 133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : ASTRIDA KALNINS

To VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2013_205129_0007, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure that when a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

The notification shall include requirements outlined in O.Reg. 79/10, s. 107 (1) (2) (3) (3.1) (4) (5) (6) (7).

Grounds / Motifs :

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

1. Review of the homes complaint log revealed a written complaint titled "Formal Complaint of Patient Neglect". The written complaint was received by the home and a review of the Ministry of Health and Long Term Care (MOHLTC) Critical Incident System revealed no report was received regarding the alleged abuse. Review of the homes critical incident (CI) log on June 12, 2014 revealed no record of a CI submission. The Director of Administration DOA confirmed the allegation of patient neglect had not been reported immediately to the Director. (510)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 11, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
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.
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.
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.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the use of PASD under subsection (3) to assist a resident with a routine activity of living may be included in the 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.
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.
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.
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.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

The licensee shall include in the plan, the following:

1. The development and implementation of a training program to ensure staff understand the use of PASD, according to the home's policy and the requirements under legislation.

2. An ongoing process to ensure the use of PASD is included in the residents plan of care and includes all the requirements of s. 33 (4).

The plan is to be submitted to Yvonne Walton Inspector for MOHLTC. Yvonne.Walton@ontario.ca by July 11, 2014

Grounds / Motifs :

1. The licensee did not ensure 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. Resident #8, 9, 15 all use bed rails to assist them with transferring in and out of bed and to assist with bed mobility, however the licensee did not ensure alternatives have been considered. The Registered Nursing staff and Director of Care confirmed this. (169)

2. The licensee did not ensure that the use of the PASD was consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give consent. Resident #8, #9 and #15 did not provide consent to the use of the PASD, bed rails. The clinical documentation, Registered Staff and Director of Care confirmed this. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 25, 2014

Ontario

Ministry of Health and Long-Term Care

Ministére 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

Order # / Ordre no : 003

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

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 prepare, submit and implement a plan to ensure the long term care home institute the following policies and they are complied with:

"Restrain and PASD Mechanical" #V3-1340
"Falls Prevention Program" #V3-630
"Responsive Behaviors Management" #V3-092
"Abuse and Neglect" V3-010
"Lost/Missing Clothing" V8-300

The plan shall be submitted to Yvonne.Walton@ontario.ca by July 11, 2014.

Grounds / Motifs :

1. The licensee did not ensure that the policy named "Restrain and PASD Mechanical" V3-1340 was complied with. The policy directs the home to review, reassess, and evaluate resident use of PASD monthly. The policy also directs the home to annually evaluate the use of PASD's, including an evaluation of what changes and improvements are required. The policy also directs the staff to document on each resident using a PASD 1. Evidence of providing care as set out in the plan of care. 2 The expected outcomes in the plan of care and 3. The evidence of the effectiveness and evaluation that the plan of care is effective.
The policy also directs staff to document: A. assessment and alternatives evaluation of PASD.

B. authorization/prescribing orders D. consent for PASD E. application of PASD and manuafacturers specifications.
These were not competed for Resident #9, #7, #4. Confirmed by the Director of Care and lack of clinical documentation. (169)

2. The home's Falls Prevention Program identified as #V3-630 and revised on November, 2013 stated that all residents will be assessed by nursing and/or physiotherapy for risk of falls on admission, quarterly, during a significant change in status and post fall. Resident #202 fell and sustained an injury. Review of the clinical record indicated that the resident was not assessed for risk of fall quarterly, during a significant change and post fall. The registered staff confirmed that the falls risk assessments were not completed for Resident #202 as per the home's policy. [s. 8 (1) (b)]
(581)

3. A formal complaint of patient neglect was received by the home.
Policy #V3-010, Abuse and Neglect Resident directs the charge nurse in the home will immediately report any improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. The policy requires immediate reporting to the Ministry of Health and Long Term Care (MOHLTC) Director by initiating a mandatory Critical Incident System (CIS) report. Contact information for business hours and for after hours contact is provided in the policy .
The written follow up letter from the Director of Care (DOC) to the family (complainant) indicated a copy of the response was sent to the MOHLTC. The DOC advised that all written complaints are submitted to the MOHLTC. Review of the MOHLTC log determined there was no record of this Critical Incident being reported to the MOHLTC. The DOC confirmed this complaint of alleged neglect was not reported immediately as required by the Homes policy for a Critical Incident. (510)

4. Staff did not comply with directions contained in the homes policy Responsive Behaviours Management identified as # V3-092 and dated March 2012. The policy directed that a management strategy for responsive resident behaviour include the assessment and identification of behavioural triggers where possible. Documentation in Resident #304's clinical record in the Point of Care (POC) indicated that the resident demonstrated behaviours eight times over a four week period of time. Clinical documentation and the Director of Resident Care confirmed that there was not an attempt to identify possible triggers for this new

responsive behaviour being demonstrated by the resident. (129) (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 25, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure safety issues related to the use of bed rails are addressed. The plan is to include but is not limited to:

1. The development and implementation of a training program to ensure staff identify and report when there are safety concerns related to the use of bed rails.

2. A schedule of ongoing monitoring of all bed rails in the home to ensure that the bolt mechanism secures the bed rail to the bed tightly.
The plan is to be submitted to Yvonne.Walton@ontario.ca and Phyllis.Hiltz-Bontje@ontario.ca by July 11, 2014.

1. Previously identified as non-compliant on April 24, 2014
2. Related non-compliance [O. Reg. 15(1) a] identified on April 16, 2013 as a CO and April 24, 2014 as a VPC.

Grounds / Motifs :

1. The licensee did not ensure Resident #4, #7 and #9 were assessed and their bed systems evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the residents. On June 10 and 11, 2013 all three residents were observed with side rails in the up position while in bed. The clinical documentation was reviewed and there were no assessments completed for the use of the bed rail or of their bed systems, to minimize risks to the residents.
Interview with the physiotherapy staff, nursing staff and the Director of Care confirmed there wasn't an assessment completed. (169)

2. The licensee did not ensure that where bed rails were used in the home that safety issues related to the use of bed rails were addressed, in relation to the following: [15(1)(c)]
The licensee did not ensure that bed rails being used for Resident #001 and Resident #015 were properly secured to the bed frames.
-On June 5, 2014 it was noted that the quarter rail attached to the side of Resident #001's bed was loose and could be moved away from the mattress leaving a four and one half inch gap between the mattress and the bed rail.
-One June 5, 2014 it was noted that the quarter rail attached to the side of Resident#015's bed was loose and could be moved away from the mattress leaving a four inch gap between the mattress and the bed rail.
The DRC confirmed that this has been an ongoing issued and is caused by the bolt that secures the bed rail to the bed frame becoming loose. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 04, 2014

Ontario

Ministry of Health and Long-Term Care

Ministére 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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. The plan is to include but is not limited to:

The development and implementation of a training program to ensure staff use safe transferring and positioning devices and techniques when assisting residents, especially mechanical lifts.

The plan shall be submitted to Yvonne.Walton@ontario.ca by July 11, 2014

Grounds / Motifs :

1. The licensee did not ensure that staff used safe transferring and positioning devices or techniques when assisting residents, in relation to the following While being transferred by two Personal Support Workers (PSW) with a mechanical lift , Resident #212 fell and sustained an injury . Interview with PSW and Registered staff confirmed the Resident did fall while being transferred by the mechanical lift but could not identify the contributing factors that caused the fall. The staff did not ensure that safe transferring techniques were used when assisting resident #212. (581)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 25, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to Resident #3, and ensure all residents receive nutritional supplements as prescribed.

The plan shall be submitted to Viktoria.Shihab@ontario.ca by July 11, 2014.

Grounds / Motifs :

1. The licensee did not ensure that care set out in the plan of care was provided to Resident #3 as specified in the plan.

Clinical records for Resident #3 indicated that the resident was at high nutritional risk with suboptimal nutritional intake requiring nutritional supplementation. The resident had a history of low body weight. Based on Registered Dietitian (RD) recommendations, a physician's order was placed for Resource three times daily. No documentation was found to verify that the resident received the prescribed supplement. Interviews with the resident's full time nurse, charge nurse and Director of Care confirmed the resident was not provided with the supplement. (584)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 25, 2014

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

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 7th day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : YVONNE WALTON

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