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**

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
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Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 15, 2013 | 2013_128138_0037 | O-000779-13 | Critical Incident System |

**Licensee/Titulaire de permis**

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

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

PAULA MACDONALD (138)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 26, 2013**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nutritional Care Manager, and a Registered Practical Nurse.**

**During the course of the inspection, the inspector(s) reviewed Critical Incident Report, reviewed a resident's health care record, reviewed Dining Room Meal Reference Sheet, and observed a meal service.**

**The following Inspection Protocols were used during this inspection:**
**Nutrition and Hydration**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, s. 6. (7) in that the licensee failed to ensure that the care set out in the nutritional plan of care was provided to a resident as specified in the plan.

The Ministry of Health and Long Term Care received a Critical Incident Report (CIR) that outlined Resident #1 was transferred to the hospital related to a choking incident that occurred at the home on a day in August 2013. The CIR further outlined that the resident had previously been identified by the home as having a peanut allergy and, at the time of the incident had been provided peanut butter by a personal support worker (PSW).

Long Term Care Homes Inspector #138 spoke with the home's Administrator and the Director of Care regarding the CIR and the Administrator reported to the inspector that the home had made a mistake in that Resident #1 who had been identified has having a peanut allergy was provided peanut butter by PSW #1. The Administrator further stated that upon his investigation into the incident he determined that PSW #1 did not verify Resident #1's nutritional care needs prior to serving the resident's meal. Both the Administrator and Director of Care stated that it is the responsibility of the personal support workers to verify residents' nutritional needs prior to serving them their meals. The Administrator continued to explain that it was determined through this incident that the resident did not have a true allergy to peanuts and that the resident's choking was not caused by an allergic reaction but rather a contributing factor to the choking incident was that PSW #1 provided the resident the incorrect texture of toast. The Administrator then directed the inspector to review the resident health care record for further details.

Discussion was held with the home's Nutritional Care Manager (NCM) who was able to provide the Dining Room Meal Reference Sheet that was in place at the time of Resident #1's choking incident. The NCM stated that the Dining Room Meal Reference Sheet is an extension of the residents' plan of care and its purpose is to guide staff in meeting the nutritional care needs of residents during meal service. The NCM further stated that it is the responsibility of the personal support worker to verify residents' nutritional needs with the Dining Room Meal Reference Sheet prior to serving residents' meals.

The Dining Room Meal Reference Sheet in place at the time of the choking incident was reviewed and it indicated that Resident #1 was to receive a pureed texture diet,

honey thick fluids, and specifically indicated no toast as well as a peanut allergy.

Long Term Care Homes Inspector #138 reviewed Resident #1's health care record and it was noted that the care plan dated July 2013 in Point Click Care identified Resident #1 at high risk of aspiration and choking, was to have a regular diet, minced texture, honey thickened fluids, and had a peanut allergy. A progress note entered two days later indicated that Resident #1's diet was changed to a pureed texture. A progress note dated a few days later in July 2013 stated that the resident was provided regular fluids at the meal service rather than the honey thick fluids that s/he was to receive and on a day in August 2013 there were two progress note entries that stated Resident #1 had a choking incident and that s/he was provided toast as well as peanut butter.

In summary, Resident #1 was not provided nutritional care according to his/her plan of care when, on a day in July 2013, s/he received and drank a glass of regular consistency fluids despite having a plan of care for honey thick fluids and again on a day in August 2013, when s/he received toast and peanut butter when the Dining Room Meal Reference Sheet indicated no toast and a peanut allergy. [s. 6. (7)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

**Issued on this 15th day of October, 2013**

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

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | PAULA MACDONALD (138) |
| **Inspection No. / No de l'inspection :** | 2013_128138_0037 |
| **Log No. / Registre no:** | O-000779-13 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Oct 15, 2013 |
| **Licensee / Titulaire de permis :** | DEEM MANAGEMENT LIMITED<br>2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5 |
| **LTC Home / Foyer de SLD :** | WELLINGTON HOUSE NURSING HOME<br>990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | |

To DEEM MANAGEMENT LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # /**
**Ordre no :** 001

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

**Linked to Existing Order /**
**Lien vers ordre existant:** 2013_184124_0014, CO #001;

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall ensure that residents nutritional care needs with respect to allergies, texture modifications, and fluid consistency modifications are provided to residents as specified in the residents' plan of care.

**Grounds / Motifs :**

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, s. 6. (7) in that the licensee failed to ensure that the care set out in the nutritional plan of care was provided to a resident as specified in the plan.

The Ministry of Health and Long Term Care received a Critical Incident Report (CIR) that outlined Resident #1 was transferred to the hospital related to a choking incident that occurred at the home on a day in August 2013. The CIR further outlined that the resident had previously been identified by the home as having a peanut allergy and, at the time of the incident, had been provided peanut butter by a personal support worker (PSW).

Long Term Care Homes Inspector #138 spoke with the home's Administrator and the Director of Care regarding CIR and the Administrator reported to the inspector that the home had made a mistake in that Resident #1 who had been identified has having a peanut allergy was provided peanut butter by PSW #1. The Administrator further stated that upon his investigation into the incident he determined that PSW #1 did not verify Resident #1's nutritional care needs prior to serving the resident's meal. Both the Administrator and Director of Care stated that it is the responsibility of the personal support workers to verify residents' nutritional needs prior to serving them their meals. The Administrator

continued to explain that it was determined through this incident that the resident did not have a true allergy to peanuts and that the resident's choking was not caused by an allergic reaction but rather a contributing factor to the choking incident was that PSW #1 provided the resident the incorrect texture of toast. The Administrator then directed the inspector to review the resident health care record for further details.

Discussion was held with the home's Nutritional Care Manager (NCM) who was able to provide the Dining Room Meal Reference Sheet that was in place at the time of Resident #1's choking incident. The NCM stated that the Dining Room Meal Reference Sheet is an extension of the residents' plan of care and its purpose is to guide staff in meeting the nutritional care needs of residents during meal service. The NCM further stated that it is the responsibility of the personal support worker to verify residents' nutritional needs with the Dining Room Meal Reference Sheet prior to serving residents' meals.

The Dining Room Meal Reference Sheet in place at the time of the choking incident was reviewed and it indicated that Resident #1 was to receive a pureed texture diet, honey thick fluids, and specifically indicated no toast as well as a peanut allergy.

Long Term Care Homes Inspector #138 reviewed Resident #1's health care record and it was noted that the care plan dated July 2013 in Point Click Care identified Resident #1 at high risk of aspiration and choking, was to have a regular diet, minced texture, honey thickened fluids, and had a peanut allergy. A progress note entered two days later in July 2013 indicated that Resident #1's diet was changed to a pureed texture. A progress note a few days later stated that the resident was provided regular fluids at the meal service rather than the honey thick fluids that s/he was to receive and on a day in August 2013 there were two progress note entries that stated Resident #1 had a choking incident and that s/he was provided toast as well as peanut butter.

In summary, Resident #1 was not provided nutritional care according to his/her plan of care when, on a day in July 2013, s/he received and drank a glass of regular consistency fluids despite having a plan of care for honey thick fluids and again on a day in August 2013, when s/he received toast and peanut butter when the Dining Room Meal Reference Sheet indicated no toast and a peanut allergy.

Previous non compliance for LTCHA, 2007 S.O 2007, c.8, s. 6. (7) was issued on:

1) May 9, 2013 as a Written Notification/Voluntary Plan of Corrective Action as part of inspection 2013_184124_0008 (log # O-001178-12 and O-002402-12) relating to bed alarms and wound care.

2) August 14, 2013 as Compliance Order #001 as part of inspection 2013_184124_0014 (O-000591-13) with respect to toileting in accordance with plan of care.
This Compliance Oder had a compliance date of August 23, 2013.
It has not been inspected for compliance and remains outstanding.
Refer to to inspection report 2013_184124_0014 dated Aug 14, 2013 for specific details.

(138)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 29, 2013

## 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 15th day of October, 2013**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** PAULA MACDONALD

**Service Area Office /**
**Bureau régional de services :** Ottawa Service Area Office