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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 19, 2017	2017_644507_0006	009715-17	Resident Quality Inspection

Licensee/Titulaire de permis

INA GRAFTON GAGE HOME OF TORONTO
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

INA GRAFTON GAGE HOME
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

STELLA NG (507), ANGIE KING (644), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 23 – 26, 29 – 31, June 1 – 2, 5 – 7, 2017.

The following critical incident reports were inspected concurrently with the Resident Quality Inspection (RQI):
 # 010116-17 related to abuse, and
 # 032113-16 related to responsive behaviours.

The following complaints were inspected concurrently with the RQI:
#035061-16 related to nutrition and hydration, menu planning and falls prevention, and
#005734-17 related to nutrition and hydration.

The following follow up inspection was inspected concurrently with the RQI:
#003705-17 related to abuse prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Manager (NM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Staff Educator, Program Manager (PM), Recreation Aide (RA), Physiotherapist (PT), Director of Environmental Services (DES), Registered Dietitian (RD), Food Service Supervisor (FSS), Cooks, Dietary Aides (DAs), Housekeeping Aides (HAs), residents, substitute decision makers (SDMs) and family members of residents.

The inspectors conducted observations of staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **8 VPC(s)**
- **0 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_334565_0009	589

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted.

On an identified date at an identified time, the inspector observed from the hallway that the door to an identified resident's room was open, and the identified resident was in bed with only a top and a continence product on with no other cover in place. Five seconds later, staff #100 came out from the resident's washroom and went to another resident's room across the hallway.

In an interview, staff #100 stated that while he/she was filling the basin with water in the resident's washroom to provide morning care to the resident, he/she realized that he/she had forgotten the towels. Staff #100 then went to the nearest care cart which was located in another resident's room across the hallway to get supplies. Staff #100 covered the resident with the bed sheet when the inspector brought to his/her attention that anyone could observe the resident not covered appropriately from the hallway.

Observations by the inspector on the same day for approximately 30 minutes, revealed that the identified resident was provided morning care in bed by staff #100 and #101. During the observation, the inspector did not observe either staff #100 or #101 explain to the resident what they were going to do prior to turning and providing peri care to the resident.

Record review of the identified resident's most recent kardex, revealed that staff were to explain each activity/care procedure prior to beginning of care to the resident.

Interviews with staff #100 and #101 revealed that they were busy in the mornings in getting residents ready for breakfast, and they had forgotten to explain to the resident each activity/care procedure to him/her on the above mentioned date.

In an interview staff #112 revealed that it is the home's expectation that staff are to respect resident's right and dignity at all times. Staff #112 confirmed that the identified resident's dignity was not respected by staff #100 and #101 on the above mentioned date. [s. 3. (1) 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 the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted, 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with complement with each other.

A) During stage one of the Resident Quality Inspection (RQI), an identified resident indicated to the inspector that he/she did not want to be woken up too early.

In an interview, staff #102 stated he/she was aware of the identified resident not wanting to be woken up early and having to wait for breakfast. Staff #102 further stated that since

the resident required increased assistance with personal care and mobility a few weeks ago, the resident preferred to be woken up and assisted with morning care at a specified time frame.

Review of the identified resident's most recent care plan, revealed that the resident's usual bedtime and waking time were identified, but failed to reveal the above mentioned preferred time of receiving morning care.

In an interview, Staff #103 stated he/she was not aware of the resident's current preference of receiving morning care at the specified time frame. Staff #103 further stated that it was the PSWs' duties to provide morning care to residents, and he/she did not receive any information from any PSW in regards to the resident's preference of waking up and receiving morning care at the specified time frame.

In an interview, staff #112 stated that the home's expectation is for PSWs to inform registered staff of residents' changes of routine and/or conditions, and registered staff are required to update the care plan accordingly before their shift ends. In this case, the home has failed to ensure that the staff and others involved in the different aspects of care of the above mentioned resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with complement with each other.

B) On an identified date at an identified time, the inspector observed staff #100 assisting an identified resident brushing his/her teeth with a regular toothbrush.

Review of the identified resident's most recent kardex, revealed that staff were to use alternate oral care method when providing dental care.

In an interview, staff #100 stated he/she stopped using the alternate oral care method for the resident a few months ago because the alternate oral care method made the resident shake. Staff #100 further stated he/she had informed the family that he/she was using the regular toothbrush instead when assisting the resident with his/her dental care.

In an interview, staff #105 stated that when a PSW observes a change in a resident's condition and/or routine, the PSW should inform the registered staff, and the registered staff would conduct an assessment and update the care plan accordingly. Staff #105 further stated he/she was not aware staff were using a regular toothbrush, instead of the alternate oral care method when providing dental care to the resident.

In an interview, staff #112 stated that the home's expectation is for PSWs to inform registered staff of residents' changes of routine and/or conditions, and registered staff are required to update the care plan accordingly before their shift ends. In this case, the home has failed to ensure that the staff and others involved in the different aspects of care of the above mentioned resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with complement with each other [s. 6. (4) (b)]

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

A) On an identified date, during lunch service the inspector observed staff #134 had not provided encouragement to an identified resident to eat, and removed the plate when the resident stopped eating. Further observation revealed that resident had eaten less than 25 per cent of his/her lunch. The inspector brought this to staff #116's attention. Staff #116 asked staff #134 to return the resident's plate, which he/she complied with. The inspector observed the resident finished his/her plate.

Review of the resident's written plan of care completed on an identified date, revealed that the resident was at high nutritional risk, required assistance with eating. Staff were directed to spend extra time with the resident during meals. If the resident was not eating, staff should leave him/her and re-approach in five minutes and allow sufficient time to eat.

In an interview, staff #134 stated that the resident's plate was removed as he/she thought the resident had stopped eating. Staff #134 further stated he/she should have asked the resident whether he/she had finished eating lunch and/or encouraged the resident to eat more prior to removing the plate.

In an interview, staff #116 stated the identified resident takes time to eat his/her meal. Staff #116 acknowledged that staff #134 should had given the resident more time to eat. In this case, the home has failed to ensure that the care set out in the plan of care is provided to the above mentioned resident as specified in the plan.

B) On an identified date, during breakfast service the inspector observed that an identified resident was served a specified diet.

Review of Diet List for the identified floor dining room revealed that the identified resident required a specified beverage at breakfast daily.

In an interview, staff #141 stated he/she had not provided the specified beverage during breakfast daily to the identified resident as he/she was not aware that the resident required the specified beverage and acknowledged that he/she had not reviewed the diet list prior to serving the resident.

In an interview, staff #120 stated that identified resident required the specified beverage at breakfast daily. In this case, the home has failed to ensure that the care set out in the plan of care is provided to the above mentioned resident as specified in the plan. [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,
a) the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with complement with each other, and
b) the care set out in the plan of care 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. 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 has failed to ensure where the Act of this Regulation requires the licensee of a long-term care to have, institute or otherwise put in place any plan, policy, protocol, procedure or system, the licensee is required to ensure that the plan, policy, protocol, procedure or system, is complied with.

During stage one of the RQI, an identified resident triggered for fall in the last 30 days, under Falls Prevention.

O. Reg. 79/10, under s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Review of the home's Fall Prevention Program, revised May 2016, under quality management, roles of the interdisciplinary team revealed the role of the unit supervisor is to make referrals to other disciplines including occupational therapy (OT) and physiotherapy (PT) after a fall incident.

Review of the identified resident's health record in Point Click Care (PCC) under the assessment tab and in the progress notes under post fall-physio, revealed physio had not completed a post-fall documentation for the fall incident from the identified date.

In an interview, staff #116 stated completing a post-fall referral to PT is required and that he/she had missed completing a PT referral post-fall for the identified resident.

Review of the resident's resident assessment instrument - minimum data set (RAI-MDS)

quarterly assessment completed on an identified date, revealed staff #134 had indicated that no fall incidents had occurred in the past quarter.

In an interview, staff #134 stated post-fall referrals to PT are required to be completed post every fall incident and that he/she had not received a referral for the identified resident's fall incident on the above mentioned date.

In an interview, staff #130, who is also the lead for the Falls Prevention program acknowledged that staff had not completed a PT referral for the above mentioned resident's fall incident and therefore had not complied with the home's Falls Prevention Program [s. 8. (1) (a),s. 8. (1) (b)]

2. On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint related to a fall in which an identified resident sustained an injury.

Review of the home's Post Fall Assessment policy under Quality Management revised May 2016, revealed on paragraph 4 that a resident will be assisted to get up only if it has been determined that the resident can be moved. Staff are directed to observe for facial expression, guarding or complaints of pain. If the resident is unable to weight bear, not to move the resident, to call ambulance and prepare to transfer the resident to hospital for assessment.

Review of the identified resident's progress notes revealed that on the identified date at an identified time, the identified resident had an unwitnessed fall while in a common area. staff #139 and #140 assisted the resident to a chair, as the resident had refused to remain on the floor. Both staff assessed the resident and noted that the resident was not able to move one part of his/her body. Staff #139 and #140 transferred the resident from the common area to his/her room and then transferred the resident from the chair to bed. Staff #140 re-assessed the resident and initiated the process to transfer the resident to the hospital.

In an interview, staff #139 stated he/she had asked the resident to remain on the floor until the assessment was completed, but the resident was adamant on sitting on a chair. Staff #139 confirmed that he/she and staff #140 had transferred the resident from the floor to the chair prior to the completion of the assessment to calm the resident. Staff #139 stated that staff #140 had made the decision to transfer the resident to his/her bed.

In interviews, staff #130 and #112 stated that both staff had not followed the home's

policy, as they moved the above mentioned resident prior to determining whether he/she could be moved. [s. 8. (1) (a),s. 8. (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 where the Act of this Regulation requires the licensee of a long-term care to have, institute or otherwise put in place any plan, policy, protocol, procedure or system, the licensee is required to ensure that the plan, policy, protocol, procedure or system, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

On an identified date, during breakfast service on an identified dining room, the inspector observed an identified resident was offered a breakfast did not include protein.

On the next day, during lunch service on the same identified dining room, the inspector observed the same identified resident was offered a specified food instead of planned menu items.

In an interview, the identified resident stated to the inspector that he/she ate the food offered because the family had not provided his/her meal for lunch on that day. The resident further stated the certain food that he/she likes to eat to the inspector.

Review of the identified resident's current written plan of care revealed he/she was on a therapeutic diet. The resident was at high nutritional risk.

In interviews, staff #131 and #129 stated that the identified resident's family member had been providing food at meal times most of the time. They stated that whenever food had not been provided by the resident's family, the resident would be offered a specified food most of the time. Staff #131 further stated that the resident had not been offered the second choice of the menu of the day, because he/she had assumed the resident would have refused to eat it.

In an interview, staff #120 stated the identified resident should have been provided protein and variable food items. Staff #120 confirmed that the above mentioned resident had not been provided with food that was nutritious and varied. [s. 11. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Review of the home's Abuse and Neglect policy Index I.D.: P-10, revised on March 17, 2017, under paragraph 18 revealed that any alleged, suspected or witnessed incident of abuse or neglect of a resident is to be made to the Administrator/designate of the home, who will immediately commence an investigation.

An identified Critical Incident System (CIS) report was submitted to the MOHLTC related to alleged abuse. Review of the CIS revealed that on an identified date, an identified resident told staff that staff #122 had abused him/her. Further review of the CIS revealed that the alleged abuse was submitted to the Director two days later.

Review of the home's investigation notes revealed and interview with staff #122 confirmed that staff had reported the alleged abuse to the management team two days after becoming aware of the incident. Staff #122 acknowledged that after becoming aware of the alleged abuse, staff should had reported it immediately as per home policy. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #6: 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 devices or techniques when assisting residents.

On an identified date at an identified time, the inspector observed staff #117 transferring an identified resident from chair to toilet without assistance from another staff member.

Review of the identified resident's written plan of care, revealed that the resident required two persons assistance for transfers using the mechanical lift.

In an interview, visitor #153 stated staff #117 had called him/her to watch the staff transfer the identified resident. Visitor #153 also stated that he/she was not able to do so as he/she was caring for another identified resident. Visitor #153 stated that he/she was not aware that staff #117 wanted him/her to assist with the transfer, as he/she had not received training on lifts and transfers from the home.

In an interview, staff #117 confirmed that he/she had transferred the identified resident without assistance, as the resident was impatient. Staff #117 stated he/she was aware that the resident required two persons assistance using the mechanical lift for transfer from one surface to another.

In interviews, staff #116 and #130 stated that the identified resident required mechanical standing lift for all transfers and staff should not operate the mechanical standing lift without a second staff member's assistance. Both acknowledged that staff #117 had used unsafe transfer technique, when assisting the above mentioned resident with mechanical lift unassisted. [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 devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council meeting minutes on an identified date, revealed that concerns related to towel supplies and meal services were raised during the meeting. Review of the Residents' Council Concerns forms revealed that the above mentioned concerns were sent to the appropriate department head eight days later, and were signed by the Residents' Council President one month later.

In interviews, staff #107 and #126, stated that prior to April 2017, concerns raised during Residents' Council meetings were responded verbally during the meetings. From April 2017, staff #107 was to complete the Residents' Council Concern form for any concerns raised by the Residents' Council, send to the appropriate department head for action; then send to the Administrator for comments and signature. Once the completed Residents' Council Concerns form has been reviewed and signed by the Residents' Council President, the form will be posted on the Residents' Council board in the lobby.

In an interview, staff #126 acknowledged that the Residents' Council was not provided a written response within 10 days for the concerns raised as required. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that respond in writing is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that an individualized menu is developed for the resident whose needs cannot be met through the home's menu cycle.

On an identified date, during lunch service on an identified dining room, the inspector observed an identified resident had not been offered planned menu items.

Review of the identified floor's diet list revealed that the identified resident is on a therapeutic diet. Further review of the diet list revealed the resident's food restrictions.

Review of the resident's most recent written plan of care revealed that the resident is at high nutritional risk. Further review of the resident's written plan of care revealed the food resident liked to eat and the Food Service Supervisor (FSS) was responsible for substituting appropriate meal items and monitoring the resident closely.

Review of the Fall/Winter menu cycle for week 2 failed to reveal a menu that meets the identified resident's dietary needs related to the resident's food restrictions.

In an interview, staff #114 revealed that a menu had not been developed to meet the resident's nutritional needs.

In an interview, staff #120 stated that the current planned menu cycle do not meet the resident's nutritional needs due to multiple food restriction. Staff #120 confirmed that an individualized menu had not been developed for the above mentioned resident. [s. 71. (5)]

2. The licensee has failed to ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m..

During the course of the inspection, the inspectors observed that breakfast service had not been available at 0830 HR.

On an identified date, the inspectors observed the following:
- at 0837 HR, 17 residents were sitting at the dining room tables on an identified dining room, and breakfast had not been served,
- at 0844 HR, 11 residents were sitting at the dining room tables on a second identified dining room, and breakfast had not been served,
- at 0846 HR, 19 residents were sitting at the dining room tables on a third identified dining room, and breakfast had not been served, and
- at 0850 HR, 14 residents were sitting at the dining room tables on a fourth identified dining room, and breakfast had not been served.

On a second identified date, the inspectors observed the following:
- at 0840 HR, 16 residents were sitting at the dining room table on an identified dining room, seven residents were having porridge, and breakfast had not served to nine residents,
- at 0840 HR, 18 residents were sitting at the dining room table on a second identified dining room, and breakfast had not been served.
- at 0845 HR, 18 residents were sitting at the dining room table on a third identified dining room, and breakfast had not been served, and
- at 0850 HR, 20 residents were sitting at the dining room tables on a fourth identified dining room, and breakfast had not been served.

On a third identified date, the inspector observed that the food carts left the production area at 0835 HR, and arrived at an identified dining room at 0840 HR. Full breakfast service started at 0850 HR.

Review of the Pleasurable Dining Room Audit completed during breakfast on an identified dining room on an identified date, on section 10 revealed that meal service started at 0845 HR and ended at 0940 HR.

In interviews, staff #114, #118 and #122 acknowledged that breakfast had not been served up to at least 0830 HR. [s. 71. (6)]

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 an individualized menu is developed for the resident if their needs cannot be met through the home's menu cycle, and a full breakfast is available to residents up to at least 8:30 a.m. and the evening meal not served before 5:00 p.m, to be implemented voluntarily.

WN #9: 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,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system provide for documentation on the production sheet of any menu substitutions.

Review of the Fall/Winter menu cycle for week 1 (May 21 – 27, 2017) and week 2 (May 28 – June 3, 2017) revealed that assorted fresh fruits were planned for breakfast daily.

On an identified date during week 1, during breakfast service, the inspector observed canned fruit salad instead of fresh fruits was served. On an identified date during week 2, during breakfast service, the inspector observed apple sauce instead of fresh fruits was served.

Review of the Menu Changes Tracking Sheet for 2017, failed to reveal that substitutions had been made on the above identified dates in regards to assorted fresh fruits.

In an interview,staff #128 stated that he/she had substituted assorted fresh fruits with canned fruits and apple sauce on the above identified dates, and had not documented the substitution on the production sheets.

In an interview, staff #114 stated that staff are directed to record all substitutions on the production sheet, and he/she acknowledged that the above substitution had not been recorded on the production sheet. [s. 72. (2) (g)]

Issued on this 6th day of July, 2017

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

Original report signed by the inspector.