Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

Name of Inspector:	Michelle Warrener	**Inspector ID #**	107
Inspection Report #:	2010_107_1500_20Jul141501 2010_127_1500_20Jul160521 2010_147_1500_26Jul102910 2010_167_1500_20Jul124114 2010_171_1500_20Jul141510		
Type of Inspection:	Follow Up		
Licensee:	1508669 Ontario Limited c/o Deloitte & Touche Inc. 181 Bay Street Brookfield Place, Suite 1400 Toronto ON M5J 2V1		
LTC Home:	West Park Health Centre 103 Pelham Street St. Catherine's, ON L2S 1S9		
Name of Administrator:	Marjorie Mossman		

To 1508669 Ontario Limited, you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
LTCHA, 2007, S.O. 2007, c. 8, s. 5.
Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Order:
The licensee shall:

1. Secure the gates of the courtyard/garden and keep them secure at all times such that residents may not exit the property from that area.
2. Stabilize and tether to the wall all wardrobes in identified resident rooms to eliminate the risk of the wardrobes tipping over.

3. Repair the transition strip at the entrance to an identified resident room such that it sits flush and no longer poses a trip hazard.
4. Repair, or replace as necessary, the toilet seats in identified resident rooms such that the toilet seats do not slip in any direction and cause any resident to slip and fall.
5. Secure the toilet to the floor in Washroom 24 such that it does not rock back and forth in any direction and cause any resident to slip and fall.

Grounds:

21 July 2010

1. The courtyard/garden gate leading to a concrete staircase was not latched or securely closed.
2. Four wardrobes were not secure and posed tipping hazards.
3. The flooring transition strip was lifted at the entrance to a resident's room.

22 July 2010

1. Slip and fall hazards due to the loose toilet seats in eight areas.
2. Slip and fall hazard due to a toilet not being secured to the floor.

This order must be complied with by:	15 November 2010

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:

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.

Order:

The licensee shall prepare, submit and implement a written plan for achieving compliance to meet the requirement that the care set out in the plan of care is provided to the resident as specified in the plan. The plan is to be submitted to Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton ON L8P 4Y7, Fax 905-546-8255.

Grounds:

The care set out in the plan of care was not always provided to residents at the lunch meal July 21, 2010:

1. Three residents did not have their prescribed nutritional supplement provided.
2. Specific menu items required for the renal menu were available, however, were not offered/provided to residents requiring the menu, resulting in residents receiving items contrary to their prescribed diet order for five residents.
3. One resident did not receive interventions identified on the plan of care to address constipation and hydration.
4. Two residents did not receive the preferred items identified on the plan of care.

The care set out in the plan of care was not always provided to residents at the lunch meal July 26, 2010:

1. In discussion with the RPN it was noted that three residents were given the incorrect nutritional supplement. The supplement formulations are not of equivalent nutritional value, resulting in the residents being provided fewer calories than their prescribed order. The residents are at nutrition risk.
2. One resident had left the dining room without being provided the ordered nutritional supplement.
3. One resident received items that were not allowed on the planned menu due to nutritional restrictions.

The care set out in the plan of care was not provided to the following residents as specified in the plan:
1. Three residents did not receive their preferred bathing preference as indicated on their plans of care.

This order must be complied with by:	26 October 2010

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O. Reg. 79/10, s. 69.1
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

Order:
The Licensee shall review all residents including the five identified and any resident who experiences a weight changes as defined by 69.1 shall be immediately assessed with interdisciplinary actions taken and outcomes evaluated as appropriate.

Grounds:

1. Five identified residents with significant weight changes were not immediately assessed with interdisciplinary actions taken and outcomes evaluated.

This order must be complied with by:	26 October 2010

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 service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed 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, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 12 day of October, 2010.	
Signature of Inspector:	M Warrener
Name of Inspector:	Michelle Warrener
Service Area Office:	Hamilton Service Area Office