Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: August 29, 2023
Inspection Number: 2023-1211-0004
Inspection Type: Complaint Critical Incident
Licensee: 488491 Ontario Inc.
Long Term Care Home and City: Avalon Retirement Centre, Orangeville

Lead Inspector	**Inspector Digital Signature**
Megan Brodhagen (000738)	Megan Brodhagen Digitally signed by Megan Brodhagen Date: 2023.09.06 12:30:20 -04'00'

Additional Inspector(s) Gabriella Del Principe (741734)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 14-18, 2023 and August 21, 2023.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00085456 was related to an unexpected death.
- Intake #00090146 was related to falls prevention and management.

The following intake was inspected in this Complaint Inspection:

- Intake #00091532 was related to multiple care concerns.

The following intake was completed in this inspection: Intake #00022682 was related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
A resident was observed without their falls interventions in place.

The resident's care plan stated that when the resident was using a specific assistive device, they were to have their falls interventions in place.

A Personal Support Worker (PSW) confirmed that the resident did not have their falls interventions in place, as per the resident's care plan.

The resident was at risk of falling when their interventions were not implemented as per their plan of care.

Sources: Observation of resident, Resident's clinical records, and interview with PSW.
[000738]

WRITTEN NOTIFICATION: Dining Service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.

The licensee has failed to comply with the process to ensure that Food Service Workers (FSW's) were aware of a resident's diet.

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to ensure that there is a process that FSW's and other staff assisting residents are aware of the residents' diets, special needs and

preferences, and must be complied with.

Specifically, the home did not comply with communicating a resident's dietary needs to the dietary staff, which was captured in the, "LTC Therapeutic Diet Extensions" policy.

Rationale and Summary
A specialized diet was initiated for a resident. The resident's care plan included specific food and fluid recommendations for the resident to consume and to avoid as part of their specialized diet.

A Food Service Worker (FSW) referred to a document, titled Diet Type Report, updated by the Food Service Manager (FSM), to find information about a resident's diet and any additional instructions. Instructions directed FSW's to see the resident's care plan for details of their specialized diet. FSW said that they did not have access to the resident's care plan and were not aware of the recommendations for their specialized diet. FSM indicated that FSW's have access to a menu binder which provides details of different therapeutic diets and the suitability of a particular menu item. However, the details of this specific diet were not included in this binder for FSW's to refer to.

Failing to provide FSW's with clear instructions placed the resident at risk of receiving menu items that may not be suitable for their specialized diet.

Sources: Resident's clinical health records; LTC Therapeutic Diet Extensions Policy; record review of Diet Type Report; interviews with staff.
[741734]