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
Jan 31, 2014	2014_191107_0005	H-000940-13	Complaint

Licensee/Titulaire de permis

BLACKADAR CONTINUING CARE CENTRE INC.
101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7

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

BLACKADAR CONTINUING CARE CENTRE
101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7

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

MICHELLE WARRENER (107), MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 13, 14, 15, 16, 17, 20, 21, 22, 23, 2014 (completed concurrently with the Resident Quality Inspection H-000032-14 of the same date)

During the course of the inspection, the inspector(s) spoke with The resident and resident's family, The Administrator, Nutrition Services Manager/Environmental Manager, Registered Nursing staff, Personal Support Workers, Dietary Aides

During the course of the inspection, the inspector(s) Observed meal service, reviewed the resident's clinical health record, and relevant policies and procedures

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 30(2)]
Actions taken with respect to resident #101 under the nutrition and hydration program, including assessments, reassessments, interventions and the resident's responses to interventions were not documented. Documentation on the resident's food and fluid intake records reflected the resident was not consistently meeting their estimated fluid requirements (24/26 days less than fluid requirement in one month; 30/31 days the next month; and 18/22 days to date in the next month). The "EO Nutrition - Priority Screen", completed by the Registered Dietitian, identified the resident was consistently not meeting their hydration requirement, however, strategies to address the poor fluid intake or an evaluation of the reduced fluid intake was not documented. Registered nursing staff stated that the resident was drinking well and consumed additional fluids, however, this was not documented and included as part of the food and fluid intake records. Interview with Personal Support Workers confirmed that not all staff were consistently recording all fluids the resident consumed on the food and fluid intake records. [s. 30. (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 with the regulations, section 30(2), to be implemented voluntarily.

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Issued on this 21st day of February, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
M Warrener, RD