Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 4, 5, 7, 10, 13, 2012	2012_066107_0011	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BURLOAK
5959 NEW STREET, BURLINGTON, ON, L7L-6W5

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Food Service Manager (FSM), Registered nursing staff, Personal Support Workers (PSW), Dietary Aides

During the course of the inspection, the inspector(s) Observed the noon meal service and afternoon snack service, and reviewed clinical health records related to complaint H-000945-12

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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following subsections:

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. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for resident #001 was not provided to the resident as specified in their plan. The resident's plan of care directed staff to provide a nutritional supplement in addition to their scheduled dose of nutrition supplement when the resident had eaten poorly at meals. Staff were not consistently providing the additional supplement as per the physician's order. In one month there were 29 missed doses when the resident ate poorly at meals (weight loss the next month); the consecutive month there were 14 missed doses; and in the next month there were 30 missed doses (weight loss the following month). Staff confirmed that the supplement was not consistently provided as prescribed.
2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The licensee did not ensure that the care set out in the plan of care for resident #004 was provided to the resident as specified in their plan.
a) The resident's plan of care directed staff to provide thickened fluids at meals and snacks, however, the resident was provided with thin fluids at the afternoon snack pass September 7, 2012. Staff confirmed the resident received the incorrect consistency of fluids placing the resident at risk for aspiration.
b) The resident's plan of care directed staff to provide extensive assistance with eating. The resident was provided a snack at the observed afternoon snack pass September 7, 2012, however, staff did not provide assistance for consuming the snack. The resident took 2 spoonfuls of the snack and did not consume the beverage. The resident then left the dining table without staff assistance. Assistance was later provided when identified by the Inspector.

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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
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.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 69.1]
The licensee did not ensure that resident #002 was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated after a significant (2.2kg/5.3%) weight loss in one month. Documentation in the resident's clinical health records, in addition to staff interview, confirmed that the significant weight loss was not referred to the Registered Dietitian for assessment and action was not taken to address the significant weight loss.

Issued on this 19th day of September, 2012

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

H Warnock, RD