Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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
Oct 24, 26, 27, 28, 31, Nov 1, 2, 4, 7, 10, 14, 16, 22, 28, Dec 9, 2011	2011_108110_0008	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

COLEMAN CARE CENTRE
140 CUNDLES ROAD WEST, BARRIE, ON, L4N-9X8

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

DIANE BROWN (110), NANCY A. BAILEY (174)

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 Administrator, Assistant Director of Care,Registered staff,Registered Dietitian, personal support workers, food service workers,private sitters, resident

During the course of the inspection, the inspector(s) Reviewed resident health records and policies and procedures; monitored meals and nourishment service

Refer to Inspection # 2011_108110_0009

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

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 O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. An identified resident is at high nutritional risk with interventions in place to achieve weight gain
This resident was observed and not offered all breakfast or lunch items menu items.[r. 71. (4)]

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 all menu items be offered and available at each meal and snack., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has not ensured a documented record is kept related to the May 2011 written complaint. There is no documentation of the type of action taken to resolve the complaint, including the date of the action,
time frames for actions to be taken and any follow-up action required; the date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The documentation on an identified resident's Restraint Care Flow Sheet does not include the time of removal of the device and the post restraining care provided.
2. Documentation on an identified resident's Restraint Care Flow Sheet does not consistently include every release of the device and repositioning of the resident
3. Documentation on an identified resident's Restraint Care Flow sheet does not consistently include the resident's response to the restraint.
4. The licensee did not ensure that every use of a physical device to restrain an identified resident is documented including the name of the person who applied the device and the time of application.

5. There is no documentation on the restraint monitoring flow sheet for the following dates, for one or more shifts on each date, for the monitoring and repositioning of the resident while using the restraint:
September 3,4, 10 ,27, 28 29, 30, October 1,2,3, 14, 15, 24, 25, 26, 27, 28, 29, 30, 31, 2011

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 documentation for the monitoring of an identified residents restraint includes the person who applies the device and the time of the application; all assessment, reassessment and monitoring including the residents' response; every release of the device and all repositioning and the removal or discontinuance of the device including the time of the removal or discontinuance and the post-restraining care., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. A process is not in place to ensure that food service workers and other staff assisting an identified resident with dining and snack service are aware of his/her documented preferences and interventions. Preferences and interventions identified in this residents plan of care were not provided at the breakfast, noon meals and the morning snack observed.
2. Lunch meals observed for an identified resident were not served course by course.[r. 73. (1) 8.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The General Manager confirmed that the licensee did not submit a copy of the May, 2011 written complaint to the Director along with a written report documenting the response the licensee made to the complainant.

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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
(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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. An identified resident is at high nutritional risk with interventions in place to achieve weight gain.
At lunch meals observed individuals feeding this resident were not aware of his care plan interventions. Interventions were not practiced.

An identified resident's plan of care states poor fluid intake as a problem with an interventions planned.Interventions were not practiced at a Nourishment pass observed. [s. 6. (4) (a)]
2. An identified resident's plan of care states poor fluid intake as a problem with an intervention identified. Documentation for June, July and August 2011 reveal that this identified resident has consistently refused intervention. Same identified resident was reassessed by the Registered Dietitian (RD) September 6th, 2011 with no alternative approaches considered to improve fluid intake.[s. 6. (11) (b)]
3. An identified resident's nutrition plan of care is not based on an assessment of his current preferences.
4. An identified resident's plan of care includes conflicting direction related to the diet to provide.[s. 6. (1) (c)]

Issued on this 13th day of December, 2011

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