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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
March 10, 2015	2014_370162_0016	T-1410-14	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE GIBSON LONG TERM CARE CENTRE
1925 STEELES AVENUE EAST NORTH YORK ON M2H 2H3

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

TIINA TRALMAN (162)

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): November 13, 14, 17, 18, 2014.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), resident family services manager (RFS), registered dietitian (RD), dietary manager (DM), personal support workers (PSW), dietary aides (DA), chaplain, rabbi, residents, and family members.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents' right to be properly fed and cared for in a

manner consistent with their needs was fully respected and promoted.

Resident #1 and 2's spiritual and religious needs for specialized foods were not fully respected and promoted. The home has not provided an opportunity for the residents to express their need for specialized foods to reflect their spiritual and religious observance.

Interviews with the dietary manager (DM) and the registered dietitian (RD) revealed that prior to admission, families and residents are informed that the home does not have a special kitchen to prepare specialized meals. The DM and RD indicated that alternate menu options are offered to meet residents' needs. The RD indicated that on admission, residents are asked about their cultural restrictions and what they are but they would not be asked if they require specialized foods as part of their religious observance, prior to coming to the home. The DM and the RD revealed they were not aware of resident #1 and #2's needs and preferences for specialized foods.

Resident #1 is identified as being of a particular faith and receives a prescribed diet. Record review and staff interviews confirmed that the resident regularly attends religious services. A record review revealed that on an identified date, the food service supervisor (FSS) updated the resident's care plan to discontinue the restriction of an identified food as per the resident's request, as the resident is now in a nursing home and can have it. Further record review revealed that on an identified date, when offered the option of a particular food item, the resident responded that the food item was not reflective of his/her religious observance. The home did not acknowledge or act on the residents' documented statement of not being provided specialized foods consistent with his/her needs.

Interview with the resident revealed that he/she cannot honour his/her religious observance with the current menu and indicated that he/she has no choice but to accept what is offered.

Interview with the resident #1's family member revealed that the resident ate specialized foods as part of his/her religious observance, prior to admission to the Gibson Long Term Care Centre. The family member also indicated the resident would have liked to continue receiving specialized meals, but were informed on admission that the home could not provide specialized meals. The family felt they could not pursue this matter any further.

Resident #2 is identified as being of a particular faith, is at nutritional risk related to complex health issues, and receives a prescribed diet. Record review and staff interviews confirmed that the resident regularly attends religious services and programs.

Interview with resident #2 revealed that he/she would have liked to have received specialized foods as part of his/her religious observance as in the past. The resident indicated that no one at the home offered him/her the option of specialized meals. “No one asked me anything.” The resident further indicated that although he/she is able to honour his/her religious beliefs by attending religious services, it is not the same as honouring his/her religion with specialized foods.

Interview with resident #2's family member revealed the home has not offered the resident the option of a specialized meal on admission or thereafter. The family member indicated that they have taken the resident out during religious holidays to enjoy specialized meals.

Interviews with the administrator and resident family services manager (RFS) indicated that resident’s cultural and religious observances prior to admission are reviewed. Residents of a particular faith are informed accommodations are available including alternate menu options. The administrator stated at the end of the interview, "The best we can do is bring in special frozen meals.The cost would be the responsibility of the home.” [s. 3. (1) 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 residents' right to be properly fed and cared for in a manner consistent with their needs are fully respected and promoted, to be implemented voluntary.

WN#2: 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:

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 2007, c. 8, s. 6 (4).
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and resident's needs and preferences.

Record review and staff interviews confirmed that the home has not assessed resident #1 and #2's needs and preferences for specialized foods.

Resident #1 was identified as being of a particular faith. A record review revealed that the resident receives a prescribed diet. Interview with the resident revealed that he/she is unable to observe his/her religious observance as specialized foods are not available at the home and indicated that he/she has no choice but to accept what is offered.

Interview with an identified PSW indicated an awareness of the resident's particular faith and that he/she does not take certain food items. Interview with the DM revealed that resident #1 has many food preferences and provided as requested, but was not aware the resident does not eat certain food items or expressed a desire for specialized meals. Interview with the family member indicated the resident would have liked to continue receiving specialized meals upon admission to the home. The family member indicated they purchase a specific food item for the resident which is then made available through the kitchen, so that he/she can enjoy some specialized food items.

Resident #2 is identified as being of a particular faith and needs specialized foods to meet

his/her religious requirements. The resident receives a presribed diet and nutritional interventions. Record review and interviews with the resident, family and staff revealed a progression of dietary concerns including a dislike of the home's menu selections, refusal to eat and, not being able to access specialized foods. The resident expressed frustration at not being provided specialized foods for religious observance.

Interview with an identified dietary aide (DA) revealed that resident #2 does not take certain food items. Interview with the RD revealed that resident #2's preferences are reviewed quarterly and suggestions are made only related to the residents' change in appetite and intake, and that specialized foods have not been discussed. The resident continues to be dissatisfied with the home's menu and food options offered and provided. [s. 6. (2)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A record review and staff interviews revealed inconsistent awareness of resident #1 and #2's preferences for not taking specific food items. Residents #1 and #2 are identified as being of a particular faith.

Interview with an identified staff revealed that resident #1 and #2 are of a particular faith and do not take specific food items. Interview with the DM confirmed unawareness that the residents expressed their spiritual and religious preference for not taking specific food items. [s. 6. (4) (a)]

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 the plan of care is based on an assessment of residents #1 and #2's needs and preference for specialized food and, to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of residents #1 and #2 so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with 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. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that the home is a safe and secure environment for its residents.

On November 17, 2014, resident #1 informed the inspector that the hallway in the basement level from the exercise room to beyond the recreation office is obstructed with equipment. Interview with the resident revealed that he/she regularly walks along the hallway as part of his/her walking routine. At approximately 2:00 p.m., the inspector observed clothing racks, linen carts, and numerous personal care equipment, including wheelchairs and lifts stored on the side of the hallway across from the exercise room extending to the end of the hallway. The observed equipment poses a potential trip and fall hazard to residents. Residents were observed in the exercise room at the time of the observation.

Interview with the administrator revealed that the area should be free of obstruction and equipment as residents access this hallway to the exercise room and recreation room. The administrator further indicated that this area is often used as a storage area for personal care equipment requiring repair and removal. The administrator indicated the area will be immediately cleared.

On November 18, 2014, at approximately 10:00 a.m. and at 2:10 p.m., the inspector observed a number of personal care equipment removed with the exception of a linen cart, clean clothing rack stored in the hallway across from the entrance to the exercise room; a commode, sit/stand lift, and a dolley were stored next to the entrance to the recreation office. The administrator was informed that the hallway was not free of stored personal care equipment, work equipment and carts. [s. 5.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that it shall not cause or permit anyone to make a charge or accept a payment on the licensee's behalf that the licensee is prohibited from charging for under the legislation.

According to the definitions set out in the Regulation, basic accommodation and preferred accommodation includes dietary services and raw food. Resident #1 paid the co-payment charges for dietary services and raw foods. Specialized food is an eligible expenditure under the raw food and other accommodation envelopes. To the extent that the accommodation fee does not over the full cost of the food, the licensee can claim the rest of the cost as eligible expenditures through the raw food and other accommodation envelopes pursuant to the Ministry's funding and financial management policies. The LTCHA and Regulation prohibit the licensee from charging a resident for goods and services that a licensee is required to provide to a resident.

Resident #1 currently resides at the Gibson Long Term Care Centre, is of a particular faith, and indicated that he/she cannot honour his/her religious observance on his/her current diet. Interviews with the staff, resident and family revealed that resident #1 receives a specialized food item, which is provided by the family and not made available by the licensee. A family interview confirmed they purchase and supply the resident with a specific specialized food item and other food items, on a regular basis, at least weekly. An interview with the DM, administrator and RFS revealed an awareness that the resident enjoys a specific food item, which is supplied by the family, and which the home has not reimbursed. [s. 91. (4)]

Issued on this 10th day of March, 2015

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

Original report signed by the inspector.