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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2015	2015_215123_0001	H-000805-14	Complaint

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

FAITH MANOR NURSING HOME
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

MELODY GRAY (123)

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 7, 8, 9 & 15, 2015

Concurrent inspection 2015_215123_002/H-001141-14, H-000758-14

During the course of the inspection, the inspector(s) spoke with the Director of Care(DOC) and the Associate Director of Resident Care(ADRC).

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

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. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan as evidenced by:

1. The record of identified resident #001 was reviewed including the plan of care. The plan of care indicated that the resident was at a high nutritional risk and was at risk for choking. They had problems eating and or chewing and swallowing. The resident was identified as needing one staff to provide constant encouragement; repetitive cues to swallow after each bite and to provide total assistance when necessary, remaining with the resident during meals to maintain adequate food and fluid intake and to prevent choking.

The home's investigation records including an August, 2013 letter to the resident's family were reviewed and it was noted that: The resident's dentures went missing in May, 2013. Two days later, the resident was left unattended in their room eating the afternoon snack. The resident was observed by their family member unattended and eating a block of cheese.

The Director of Care (DOC) was interviewed and confirmed the accuracy of the information in the home's investigation records.

The home did not provide resident #001 with the supervision, encouragement and or assistance they needed with eating as specified in their plan of care.

2. The record of identified resident #001 was reviewed and it was noted that the resident had altered skin integrity. The plan of care indicated that staff were to apply two treatment creams to the area as per physician order.

The resident's Medication Administration Record (MAR) May, 2013 was reviewed and it was noted that the resident was to have one treatment cream applied twice each day and a second treatment cream was to be applied twice per day. Seven blank spaces were observed in the resident's May, 2013 MAR related to the administration of one treatment cream and twelve blank spaces were observed in the resident's May, 2013 MAR related to the application of the other ointment. There was no documentation found in the resident's record including the Progress Notes to indicate that the treatment creams were applied to the resident as specified in their plan of care.

The DOC was interviewed and reported that it was the home's expectation that treatment creams were to be applied as specified in the plan of care and related documentation completed in the MAR of the resident's record.

The home did not apply the two treatment creams to resident #001 as specified in their

plan of care. [s. 6. (7)]

Issued on this 2nd day of September, 2015

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

Original report signed by the inspector.