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

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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
Dec 11, 2012	2012_200148_0007	O-002299-12	Complaint

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD, OTTAWA, ON, K1K-2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South, Limoges, ON, K0A-2M0

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

AMANDA NIXON (148)

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): December 4 and 6, 2012

During the course of the inspection, the inspector(s) spoke with the Director of Care, Assistant Director of Care, Resident Assessment Instrument Coordinator, Nutritional Manager, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aids and residents.

During the course of the inspection, the inspector(s) reviewed resident health care records including plans of care and flow sheets, reviewed the home's production menu and current menu approval by the Registered Dietitian. Observed meal service in the home and resident care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10, s.71(1)(b), in that the home's menu cycle does not include a menu for the therapeutic diet.

Inspector #148 requested a copy of the modified diabetic menu on December 4, 2012 from the Dietary Aid serving the lunch meal. The production menu was provided which lists for food items, portion size and recipe number for the regular, minced and puree menu. The Dietary Aid could not provide any written direction, guideline or menu describing the implementation of the modified diabetic menu.

Dietary Aid #S104 who was serving the lunch meal, stated there is no difference between the regular diet and the modified diabetic diet. However, when asked specifically about dessert choices for the supper meal, the Dietary Aid stated that the date squares for that meal would not be given to those on a modified diabetic diet. The Dietary Aid stated that since the date square is not made in house, it has too much sugar for the diabetic residents. Therefore, as confirmed by the Dietary Aid, diabetic residents would be given fruit for dessert and no alternate choice for dessert.

Dietary Aid #S105 who was serving the breakfast meal, stated that they will "watch the sugar" and/or if instructed make changes as instructed by registered staff for residents on a modified diabetic diet. When asked to clarify she noted that those on a modified diabetic menu would not get the raisin toast because it has sugar. When asked about desserts at meals, the Dietary Aid stated that all residents get the same dessert.

Nutritional Manager (NM) for the home stated that most desserts are provided to those on a modified diabetic diet, except for those desserts with sugar and in these cases only half a portion of regular dessert is provided to residents on a diabetic menu. NM confirmed that the production menu is the only menu on-site for staff implementation of the therapeutic and texture modified diets. Reviewed the production menu with the NM and demonstrated the lack of information for staff to follow in the implementation of the modified diabetic menu.

The home does not currently have in place a menu cycle that includes a menu for the therapeutic modified diabetic menu for both meals and snacks. As such, there is confusion among staff in the implementation of this menu. [s. 71. (1) (b)]

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 home's menu cycle includes menus for the modified diabetic menu for both meals and snacks, as provided for in O.Reg. 79/10, s.71, to be implemented voluntarily.

WN #2: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.3(1)1, in that staff did not respect the resident's dignity.

While observing the breakfast meal service, Inspector #148 observed RPN #S103 and a PSW providing feeding assistance to Resident #002. RPN #S103, who was standing to the side of the resident, was observed to roughly wash the resident's mouth and face with a face cloth, each time the resident would get upset and let out a loud noise, at this time the PSW would provide a spoon full of cereal while resident's mouth was open. RPN #S103 was also observed to give a moderate shake to the resident's shoulder and quickly raise the resident's head upright. These physical interventions were given without warning to the resident and without any verbal cue. At one point RPN #S103, still standing, had the cereal and the HCA had a glass of thickened fluid. The two staff would then alternate between each, one spoon full immediately after another, with little break in between for resident to swallow. The resident was observed to cough at this intervention, RPN#S103 wiped the resident's mouth and the alternating between spoon fulls continued.

Spoke with RPN#S103 after the breakfast meal. Inspector #148 described what was observed and the staff member acknowledged that the interventions may have been too rough. The staff member went on to describe the current health conditions of the resident that it was important to ensure that the breakfast meal was consumed. [s. 3. (1) 1.]

WN #3: 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. (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 failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(2), in that the plan of care for Resident #001 was not based on the needs of the resident.

The plan of care for Resident #001 related to hearing indicates that the resident uses hearing aids that are to be applied in the AM by registered staff.

Resident #001 was observed on the first morning in bedroom without the hearing aid applied. The resident had difficulty hearing the inspector and required repetition of the questions. The resident was observed to be provided the hearing aid at 10:00am. Resident #001 was also observed on the second morning, at the breakfast meal service without the hearing aid in place. The resident was observed to be provided the hearing aid at 10:00am.

RPN #S101 responsible for the application of the resident's hearing aid on the first morning stated that there was not enough time to provide hearing aids during the 8:00am medication pass. RPN #S102 responsible for the application of the resident's hearing aid on the second morning, stated that the aid was not applied until 10:00am because the resident was scheduled to have a bath after breakfast.

The delay in application of the resident's hearing aid is not consistent with the resident's needs. [s. 6. (2)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(7), in that the care set out in the nutritional plan of care was not provided to Resident #001.

A review of Resident #001's the health care record demonstrates that the resident has several instructions within the plan of care related to meal provision. The plan of care sets out that the resident is to receive 1/2 portion of potatoes and 2 servings of vegetable at meals.

Resident #001 was observed at a lunch meal service. The resident was observed to receive regular portions of both potato and vegetable, demonstrating that the plan of care was not provided as set out. [s. 6. (7)]

3. The plan of care for Resident #001 indicates that the resident is incontinent of bladder and bowel and that there is a scheduled toileting plan, including toileting every 2 hours. An interview with PSW #S100, stated that the resident is not on any schedule

but rather rings the call bell when toileting is needed.

The plan of care for Resident #001 indicates the resident is not always capable of remembering how to use the call bell.

As described by the PSW, there is a reliance on the resident to call for toileting assistance using the call bell, which the resident does not always remember how to use, rather than a scheduled toileting plan as set out in the plan of care. This demonstrates that the care set out in the plan of care is not being provided as specified in the plan. [s. 6. (7)]

Issued on this 11th day of December, 2012

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