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
Nov 18, 2013	2013_168202_0059	T-594-13	Complaint

Licensee/Titulaire de permis

CLURELEA LTD.
272 QUEEN STREET EAST, BRAMPTON, ON, L6V-1B9

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

GOOD SAMARITAN NURSING HOME
481 Victoria Street East, Alliston, ON, L9R-1J8

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

VALERIE JOHNSTON (202)

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): October 17, 18, 22, 23, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care, Activity Director, Registered Nursing Staff, Dietary Aide, Personal Support Workers, Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, observed meal services, reviewed the home's policies related to abuse and neglect

The following Inspection Protocols were used during this inspection:

Dining Observation

Nutrition and Hydration

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 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 failed to ensure that the care set out in the written plan of care is provided to the resident as specified in the plan. [s.6. (7)]

Resident #004's written plan of care directs staff to provide assistance for all meals and snacks, and to provide encouragement and feeding when he/she does not finish the meal. During the course of this inspection, resident #004 was observed to be sitting in the dining room at a table with two full glasses of drinks and one plate with a half portion of foods remaining and not eating. Resident #004 was observed to be unassisted with the meal as no staff were present. [s. 6. (7)]

2. Resident #005's written plan of care directs staff to provide help and encouragement with meals. During the course of this inspection resident #005 was observed to be sitting in the dining room at a table with 1/2 cup of juice, and a plate with a half portion of foods remaining and not eating. Resident #005 was observed to be unassisted as no staff were present. [s. 6. (7)]

3. Resident #009's written plan of care directs staff to provide supervision, oversight and encouragement for all meals and snacks. During the course of this inspection resident #009 was observed to be sitting in the dining room at a table with a full glass of apple juice, one full banana that had been peeled and a full bowl of cereal not eating. Resident #009 was observed to be unassisted in the dining room as no staff were present.
Staff interviews revealed that residents #004, #005 and #009 are assisted during meals, however they often require extensive periods of time to complete meals. Staff indicated that on days when residents require more time to complete their meal, residents will remain in the dining room and assisted later. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff use proper techniques to assist residents with eating, including safe positioning of residents who require assistance. [s.73.(1)10]

Residents #007, #010, #011, #012 and #013's written plan of care identifies these residents as requiring total assistance with eating and drinking. During the lunch meal service residents #007, #010, #011, #012 and #013 were observed to be assisted by staff from a standing position throughout the lunch meal service. Staff would provide a spoon of food to resident #010, reach over and provide a spoon of food to resident #011, then walk across the dining room to provide a spoon of food to resident #007 and then to resident #013. Staff continually fed residents in this sporadic manner throughout the meal service, minimal eye contact was made with residents and at times staff would spoon the food into the resident's mouths positioned from the resident's side. Staff interviews revealed that meal services are generally rushed and in order to feed all residents in a timely manner, staff are required to feed residents standing. [s. 73. (1) 10.]

2. The licensee failed to ensure that no person simultaneously assists more than two residents who need total assistance with eating or drinking. [s.73.(2)(a)].

Residents #007, #010, #011, #012 and #013's written plan of care identifies these residents as requiring total assistance with eating and drinking. During the lunch meal service residents #007, #010, #011, #012 and #013 were fed simultaneously between two staff members. A staff member was observed to provide a spoon of food to resident #010, reach over and provide a spoon of food to resident #011, then walk across the dining room to provide a spoon of food to resident #007, while the other staff member would provide a spoon to resident #013, then to #012 and walk over to assist resident #010 across the dining room.
Staff interviews revealed that they are required to feed two to three residents at a time, so that all residents are fed in a timely manner. [s. 73. (2) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (1) Every licensee of a long-term care home shall ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutrition care and dietary services program for the home. O. Reg. 79/10, s. 75 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutrition care and dietary services program for the home. [s.75(1)]

Staff interviews revealed that the home currently does not have a nutrition manager. An interview with the Administrator confirmed that the home has not had a nutrition manager since October 11, 2013, however is currently recruiting for the position. [s. 75. (1)]

Issued on this 18th day of November, 2013

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

Valerie Johnston