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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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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
Jul 29, 2016	2016_273638_0010	016145-16	Resident Quality Inspection

Licensee/Titulaire de permis

GROVE PARK HOME FOR SENIOR CITIZENS
234 COOK STREET BARRIE ON L4M 4H5

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

GROVE PARK HOME FOR SENIOR CITIZENS
234 COOK STREET BARRIE ON L4M 4H5

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

RYAN GOODMURPHY (638), HEATHER PRESTON (640), JESSICA WASYLENKI-RYAN (639), KERRY ABBOTT (631), LALEH NEWELL (147), MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 6 - 10 and June 13 - 17, 2016.

This inspection included two Critical Incidents submitted to the Director, one related to a resident who had fallen and another incident related to resident to resident physical abuse. A complaint was also submitted related to allegations of medications being taken from the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Manager of Programs and Volunteer Services (MPVS), Resident Assessment Instrument (RAI) Coordinator, Pharmacist Consultant, Restorative Care (RC), Registered Dietician (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance Workers, Physiotherapist Assistant (PTA), Food Services Aides (FSAs), Residents and Families.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed licensee policies, procedures and programs, relevant health care records and Residents' Council meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **5 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. (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 has failed to ensure that the plan of care was based on an assessment of the resident and the resident's preferences.

In an interview with Inspector #638, resident #006 stated that it was their resident's preference to have their care performed in a specific routine.

In an interview with Inspector #638, PSW #109 said that resident #006 had preferred care routines in which the staff had been following.

An interview with RPN #115 indicated that resident #006 had preferred care routines of which staff were aware.

Inspector #638 reviewed resident #006's care plan with RPN #115, which indicated that the interventions documented within the plan of care were not based on the resident's preferences and did not give clear direction to staff regarding resident #006's preferences.

In an interview with Inspector #638, the DOC indicated that it was the home's expectation to take into account the preferences of each resident when appropriate and include the preferences in the plan of care. The plan of care for resident #006 had not accommodated their preferences and should have. [s. 6. (2)]

2. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

A record review performed by Inspector #638, of the plan of care for resident #006 specified that an intervention was to be implemented at all times while the resident was up in their wheelchair in order to minimize the resident's risk of harm.

Inspector #638 observed on June 7, 2016, that the intervention for resident #006 was not implemented as per their plan of care when the resident was observed up in their wheelchair.

Further observations indicated that on June 14, 2016, the resident's intervention had not been implemented as per their plan of care while resident #006 was up in their wheelchair for the entire breakfast serving.

In an interview with Inspector #638, PSW #109 indicated that resident #006 was expected to have their interventions applied at all times while up in their wheelchair as per the interventions set out in the plan of care.

In an interview, the DOC verified that it was the home's expectation that the interventions set out in the plan of care were to be provided to the resident as specified in the plan, had not occurred and should have. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the plan of care is based on the resident's preferences when appropriate, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence based practices to minimize the risk to the resident.

On June 13, 2016, and June 14, 2016, Inspector #631 observed resident #005 in bed with two quarter bed rails in the raised position.

A review of resident #005's Minimum Data Set (MDS), indicated that resident #005 did not require bed rails for bed mobility or transfers.

In an interview with Inspector #631, PSW #118 indicated that resident #005's bed rails were raised while the resident was in bed and that this was part of the resident's care interventions.

In an interview with the DOC, they verified that it was common practice throughout the home for residents to use two quarter bed rails in the raised position. The DOC said that the home did not conduct any resident assessments or evaluate the bed systems for residents with quarter bed rails engaged, including those of resident #005. [s. 15. (1) (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 where bed rails are used, every resident is assessed and the bed system evaluated in accordance with evidence based practices, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident to staff communication response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

Inspector #631 observed on June 7, 2016, that the call bell for resident #001 was dangling from the wall and was not accessible to the resident. On June 15, 2016, Inspector #640 observed resident #001 asleep in bed with the call bell clipped to the wall connection port and not accessible to the resident.

In an interview with Inspector #631, PSW #113 indicated that all residents were to have their call bells accessible while in their rooms.

During an interview with Inspector #631, the DOC verified that it was the expectation of the home to ensure that all residents had their call bells accessible at all times. [s. 17. (1) (a)]

2. Resident #003 was observed by Inspector #640 on June 11, 2016, to be in bed with the door shut to the corridor and the call bell draped over the left side rail behind the resident.

Inspector #640 observed resident #003 on June 13, 2016, in bed and the resident's call bell was hanging from the wall approximately six feet away from the resident.

In an interview with Inspector #640, RN #107 verified the call bell was not accessible and ought to have been available to the resident all the time. [s. 17. (1) (a)]

3. During an observation by Inspector #640 on June 11, 2016, resident #008 was observed lying in bed with the call bell draped over the foot of the bed. The resident was observed on June 13, 2016, lying in bed with the call bell hanging from the wall connection port and not accessible to the resident.

In an interview with Inspector #640, RN #107 indicated that the call bell was to be accessible to the resident at all times.

In an interview with Inspector #640, the DOC verified that it was the home's expectation that all residents, regardless of cognitive ability, were to have their call bells accessible at all times. [s. 17. (1) (a)]

4. On June 11, 2016, and June 13, 2016, Inspector #640 observed resident #012 sitting in an arm chair with no access to the call bell. The resident's call bell was on the bed on the opposite side of the room during both observations.

During an observation made with Inspector #640 on June 13, 2016, PSW #105 indicated the call bell was not accessible to resident #012.

In an interview with Inspector #640, the DOC verified that the home's expectation was that all residents, regardless of cognitive ability have their call bell within reach and accessible at all times. [s. 17. (1) (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 resident to staff communication and response system can be easily seen, accessed and used by residents at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the behavioural triggers had been identified for the resident demonstrating responsive behaviours.

A record review of the Minimum Data Set (MDS) assessment records by Inspector #638 indicated that resident #009 had demonstrated an increase in responsive behaviours. Further review of the MDS assessment indicated that the resident's responsive behaviour triggers were to be implemented within the care plan on Point Click Care (PCC).

Inspector #638 conducted a review of the progress notes for resident #009, which showed that resident #009 had demonstrated responsive behaviours towards resident #050. Further review of the progress notes indicated that on another occassion, resident #009 was witnessed to have demonstrated responsive behaviours towards resident #051.

A review of the plan of care for resident #009 indicated that there were no interventions implemented for the responsive behaviours of resident #009.

A review of the home’s policy titled “Responsive Behaviour Program NUR-03-22” defined responsive behaviours as physical or verbal aggression as well as resistance to care. According to the same policy, written approaches to care including behavioural triggers that may result in responsive behaviours were to be included within the plan of care. The responsive behaviour team were to establish resident focused, interdisciplinary goals and strategies based on the assessment findings.

During an interview with Inspector #638, RN #128 indicated that resident #009 had demonstrated an increase in responsive behaviours. RN #128 stated it was the home’s expectation to indicate any changes in status and implement new behavioural triggers within the plan of care for any resident that identified with behavioural triggers. During a review of the plan of care with Inspector #638, RN #128 indicated that there were no responsive behaviours identified for resident #009 and this was not acceptable.

In an interview with Inspector #638, the DOC verified that it was the home's expectation that for each resident demonstrating a responsive behaviour, that there was at minimum, documentation within the care plan including resident specific triggers, indicators and interventions. In a subsequent interview, the DOC verified that the responsive behaviours for resident #009 as indicated within the progress notes and MDS assessments were not implemented within the plan of care and should have been. [s. 53. (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, for each resident demonstrating responsive behaviours in the home that the behavioural triggers for the resident are identified, where possible, especially those of resident #009, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply; ensuring all areas where drugs were stored were locked at all times when not in use.

On June 6, 2016, during dinner meal service, Inspector #640 observed, RPN #106 leave the medication cart unlocked and unattended. On the same date, the medication room door was observed to be propped open on multiple occasions; the medication cart and room were not within sight of the RPN.

In an interview with Inspector #640, RPN #106 stated that leaving the medication cart and medication room unlocked and unattended was not common practice within the home and should not have happened.

In an interview with the Inspector #640, the DOC indicated that it was the home's expectation that staff were to lock the medication carts and medication rooms at all times when not being monitored or in use and any other practice was unacceptable. [s. 130. 1.]

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 areas where drugs are stored, are kept locked at all times, when not in use, to be implemented voluntarily.

WN #6: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of the residents were fully respected and promoted: Every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the act.

Inspector #640 observed, on June 6, 2016, during dinner service, RPN #106 on multiple occasions, leave the medication cart with the electronic medication administration record (eMAR) unlocked and accessible to anyone.

In an interview with Inspector #640, RPN #106 indicated that the eMAR should have been locked when not in use in order to protect the Personal Health Information (PHI) of the residents and this had not occurred.

In an interview with Inspector #640, the DOC verified that it was the home's expectation that the eMAR was to be locked when not in use so no one could access its contents in order to keep the PHI of the residents confidential. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's equipment was kept clean and sanitary.

On June 7, 2016, Inspector #638 observed the assistive equipment for resident #002 soiled. Further observations on June 9, 2016, indicated the assistive equipment continued to be soiled.

On June 13, 2016, an observation made with PSW #108 identified the assistive equipment to be soiled.

In an interview with Inspector #638, PSW #108 confirmed it was the home's expectation to ensure resident equipment remained clean and sanitary.

During an interview with Inspector #638, PSW #122 indicated that the home had a weekly night shift cleaning schedule and sign off sheets for all resident equipment. PSW #122 said that it was expected that assistive equipment were cleaned immediately after use in order to preserve a clean environment for the residents.

Inspector #638 reviewed the cleaning schedule with the DOC. The DOC indicated that for resident #002, the weekly sign off sheet had only been signed as completed for three of the six weeks or 50 per cent of the time.

In an interview with Inspector #638, the DOC verified that in order to ensure the home's equipment was kept clean and sanitary, the night shift cleaning schedule was to have been signed in entirety and not signing the schedule would indicate the task had not been completed. In a subsequent interview it was indicated that it was the home's expectation that assistive equipment were cleaned after every use in order to ensure a clean sanitary environment for residents and staff, this had not occurred and should have. [s. 15. (2) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure where the use of a personal assistance services device (PASD) to assist a resident with a routine activity of living were included in the resident plan of care only if alternatives to the use of a PASD were considered and tried where appropriate, but were not effective to assist the resident in the routine activity of living.

Observations made by Inspector #640 on June 13, 2016, and June 15, 2016, indicated that two quarter rails were in the engaged position on the bed of resident #012.

Inspector #640 conducted a record review of the plan of care for resident #012 which indicated side rails were identified as a personal assist device.

In an interview with Inspector #640, RPN #121 indicated quarter rails were considered a PASD for resident #012 and that there was no documented evidence to support that a formal assessment was completed in relation to the application or use of the PASD. Further interview with RPN #121 confirmed no alternative to the bed rails were considered or trialed for resident #012.

During an interview with Inspector #631, the DOC verified that if the resident used bed rails to mobilize in bed, the rails would be considered a PASD. The DOC also stated that the home did not use PASD assessments for the use of bed rails. [s. 33. (4) 1.]

2. The licensee has failed to ensure where the use of a PASD to assist a resident with a routine activity of living were included in the resident plan of care only if the use was approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulations.

Observations made by Inspector #640 on June 13, 2016, and June 15, 2016, indicated that two quarter rails were in the engaged position on the bed of resident #012.

Inspector #640 conducted a record review of the plan of care for resident #012 which indicated side rails were identified as a personal assist device. A concurrent review of resident #012 clinical records by Inspector #640 indicated no documented approval for use of the PASD.

In an interview with Inspector #640, RPN #121 indicated quarter rails were used as a PASD for resident #012 and that there was no formal assessment documents either on paper or in Point Click Care (PCC) completed in relation to the application or use of the PASD.

In an interview with Inspector #631, the DOC verified that if the resident used bed rails to mobilize in bed, the rails were considered a PASD. The DOC also stated that the home did not use PASD assessments for the use of bed rails to aid in residents' activities of daily living. [s. 33. (4) 3.]

3. The licensee failed to ensure where the use of a PASD to assist a resident with a routine activity of living were included in the resident plan of care only if the use of the PASD was consented to by the resident or if the resident was incapable, a substitute

decision maker of the resident with the authority to give consent.

Observations made by Inspector #640 on June 13, 2016, and June 15, 2016, indicated that two quarter rails were in the engaged position on the bed of resident #012.

A review of the clinical record of resident #012 conducted by Inspector #640 indicated that consent was not obtained for using bed rails as a PASD to assist with activities of daily living.

In an interview with Inspector #640, RPN #121 verified that consent had not been obtained for the use of bed rails as a PASD for resident #012. [s. 33. (4) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered at a minimum, a between meal snack in the afternoon.

Inspector #640 observed the snack service completed by PSW #104 on June 13, 2016 on a particular home area. The Inspector observed PSW #104 fail to offer residents #038, #039, #040, #041 and #042 their between meal snack.

In an interview with Inspector #640, residents #039 and #040 stated they were not offered a snack during the afternoon pass June 13, 2016.

During an interview with Inspector #640, PSW #104 verified that residents #038, #039 and #040 were not offered their afternoon snack during the pass.

An interview with the ADOC indicated that it was the home's expectation that every resident, whether in their room or in a common area, would be offered a choice of a snack during snack passes. [s. 71. (3) (c)]

WN #10: 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. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for residents who required assistance with eating or drinking had been served a meal only when someone was available to provide assistance.

Inspector #638 observed on June 6, 2016 on a particular home area, resident #048 during the dinner meal service, waiting approximately 15 minutes with food served prior to being assisted by staff. Further observation indicated staff assisting resident #048 with half their meal, then leaving the resident to assist another resident at another table with feeding and return after another 10 minutes had passed.

Further observations indicated resident #015 was asleep in front of their meal for approximately 25 minutes before assistance was provided for the resident to begin eating.

Inspector #638 observed resident #049 waiting approximately 20 minutes with food served prior to receiving assistance from staff and upon completing half their meal, was left by staff to assist another resident, and only assisted again after another 15 minutes had passed.

In an interview with Inspector #638, PSW #122 stated meals were only to be served to the resident requiring assistance when that assistance was immediately available and the resident was not kept waiting with their meal served in front of them. It was also expected for staff to complete assisting a resident with their needs before moving on to assisting another resident elsewhere in the dining area.

During an interview with Inspector #638, the DOC verified that it was the home's expectation that a resident requiring assistance for meal service would not have been provided their meal until the assistance was available. [s. 73. (2) (b)]

Issued on this 2nd day of August, 2016

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

Original report signed by the inspector.