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 27, 2013	2013_108110_0020	T-613-13	Complaint

Licensee/Titulaire de permis

IOOF SENIORS HOMES INC.
20 Brooks Street, BARRIE, ON, L4N-5L3

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

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET, BARRIE, ON, L4N-5L3

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

DIANE BROWN (110)

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 14, 15, 18 and 19, 2013

During the course of the inspection, the inspector(s) spoke with Director of Resident Care (DORC), Assistant Director of Resident Care, Registered Staff, Registered Dietitian (RD), Speech Language Pathologist (SLP), Director of Food Service, Personal Support Workers (PSW), Food Service Workers, Cooks

During the course of the inspection, the inspector(s) Observed meal service and food production, reviewed resident health records and relevant policies and procedures

The following Inspection Protocols were used during this inspection:
Dining Observation

Food Quality

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that Resident #1's plan of care is based on an interdisciplinary assessment of the resident's nutritional status, including height, weight and any risks related to nutrition care.

Resident #1 with a significant change in health status, was fed in an unsafe feeding position. During a 7 day identified period this risk was not identified and assessed.

A review of the home's policy entitled "Dining supervised tray service" states that PSWs will position residents in an upright position. Staff interviews confirmed that an upright position was approximately 90 degrees.
A staff interview revealed that she attempted to feed Resident #1 in a reclined 65 degree position. An interview with the Director of Resident Care (DORC) confirmed knowledge that Resident #1 had not been fed in an upright, 90 degree position and initiated an intervention.

Record review and speech language pathologist (SLP) interview revealed that the SLP advised staff against feeding resident #1 in a reclined position (less than 90 degrees). Family interview confirmed that they often fed Resident #1 and confirmed that they had not received any instructions on feeding approaches or a safe feeding position. The SLP identified family's lack of awareness regarding Resident #1's safe feeding position.

2. The licensee failed to ensure the registered dietitian (RD) who is a member of the staff of the home completes a nutritional assessment for the resident on admission and whenever there is a significant change in the resident's health condition.
Resident #1 had a significant change in health status and was at high nutritional risk .
Record review indicated that Resident #1 was not assessed by the RD even though residents intake was zero to minimal. The RD confirmed that a nutritional assessment was not completed for Resident #1's significant change in status and subsequent poor intake. [s. 26. (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 there is an interdisciplinary assessment of the resident's nutritional status, including risks related to feeding positioning and to ensure that the RD completes a nutritional assessment for residents whenever there is a significant change in health condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all pureed foods are prepared using methods which preserve taste, appearance and food quality.
Observations and taste testing of pureed menu items on November 14 and 15, 2013 revealed that pureed foods were not consistently prepared to a smooth and pudding like consistency according to the recipes and home standard. The pureed peanut butter and jam sandwich was grainy in texture, pureed bean salad was not smooth and included skin residue and pureed turkey sandwich was runny and not of a pudding like consistency. Recipes were not all available for all pureed foods to guide staff in preparing the appropriate pureed product. An interview with the Director of Food Service confirmed that the pureed foods identified November 14 and 15, 2013 were not consistent with the homes' desired pureed standard and that all pureed recipes were not accurate. [s. 72. (3) (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 all pureed foods are prepared using methods which preserve taste, appearance and food quality, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques are used to assist the resident with eating, including safe positioning of residents who require assistance.

At lunch, on an identified date, Resident #2 was observed being fed in a hyper-extended position with resident's head flexed backwards. Resident #2's plan of care identifies resident with difficulties chewing and swallowing as evidenced by coughing/choking and decreased intake. The registered staff supervising confirmed that this identified resident was not in a safe feeding position and was positioned at 60 degree during feeding. The RD confirmed that Resident #2 should not have been fed in this reclined position. [s. 73. (1) 10.]

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 proper techniques are used to assist the resident #2 with eating, including safe positioning, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the family of Resident #1, who voiced complaints on an identified date received a response of what the licensee had done to resolve the complaints. Record review and a family interview confirmed that no response was provided. An interview with the DORC revealed that the complaints raised by Resident #1's family were not documented and did not follow the normal complaint process in the home. The DORC was unable to confirm that a response to all complaints was provided to the family. [s. 101. (1) 3.]

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 a response of what the licensee had done to resolve the complaint is provided to the complainant, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter. Record review and staff interview revealed that Resident #1 at high nutritional risk and poor intake was not weighed in the month of September 2013. The home's policy states all residents will be weighed and all weights will be recorded between the 1st and 10th day of each month. [s. 68. (2) (e) (i)]

Issued on this 29th day of November, 2013

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

Diane Brown