Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 17, 18, 19, 26, Oct 1, 2, 2012	2012_066107_0013	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

LINHAVEN
403 Ontario Street, St. Catharines, ON, L2N-1L5

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Residents, family members, front line dietary and nursing staff, Registered staff, the Director of Care, Administrator, Registered Dietitian, Food Services Manager

During the course of the inspection, the inspector(s) Observed the supper meal (twice) and a breakfast meal in two dining areas and reviewed resident plans of care in one home area related to complaint inspection H-00299-12.

The following Inspection Protocols were used during this inspection:

Dining Observation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)9]
Not all residents were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
a) At the observed lunch meal September 18, 2012, resident #2 was sitting in-front of their dessert without eating it. The dessert was placed without assistance being available or provided for an extended time. The resident required total assistance with eating, as per their plan of care, and the dessert was not consumed.
2. [O.Reg. 79/10, s. 73(1)7]
Not all residents were provided sufficient time to eat at their own pace.
At the supper meal September 17, 2012, a resident was not completely finished their meal when their plate was removed from the table. The resident got upset when the plate was removed. Staff interview confirmed that the supper meal was often rushed towards the end of the meal service.

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 with ensuring that there is sufficient time for every resident to eat at his or her own pace and that residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 40]
The licensee did not ensure that resident #1 was dressed appropriately, suitable to the time of day, and in keeping with their preferences on the evening of September 17, 2012. The resident was observed in the dining room in their bed clothes prior to the supper meal. Interview of front line nursing staff indicated the resident was bathed prior to the meal and then placed in their bed clothes. The resident's plan of care stated staff were not to put the resident's bed clothing on until at least 2030 or later. Management staff interviewed stated the resident's preference, and that of their family/Substitute Decision Maker, was to have the resident in their day clothes until bedtime. Staff stated the home's policy was to keep residents in day clothes when their bath time was prior to dinner.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 129.(1)(a)(ii)]
The licensee did not ensure that drugs were stored in a medication cart that was secure and locked.
The medication cart was left unlocked and unattended, in a resident area with cognitively impaired residents, at 1736 hours on September 17, 2012. The medication cart was in the hallway with the drawers facing out and accessible to residents and out of the sight-line of the Registered Practical Nurse (RPN) who was in the dining room assisting a resident. When the RPN returned to the cart they confirmed the cart was unlocked. The medication cart was also left unlocked and unattended in the same home area at 0838 and 0925 hours the morning of October 1, 2012. At 0925 a cognitively impaired resident was standing at the medication cart while it was unattended and other residents were wandering in the hallway where the cart was located.

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 with ensuring that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning
Specifically failed to comply with the following subsections:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(4)]
Not all residents were offered the planned menu items at the supper meal September 17, 2012.
The planned dessert for the pureed texture was pureed tiramisu or pureed strawberries. These items were not available to residents in one dining area at the supper meal. An alternate dessert of butterscotch pudding was offered to residents, however, this was offered in disposable dishes and an alternative dessert choice was not available for residents requiring thickened fluids. Staff interview determined that the pudding was taken from the snack service and served at the supper meal. Investigation by the Nutrition Manager determined that the pureed dessert items were made, however, were missed on the delivery cart to the servery.

Issued on this 3rd day of October, 2012

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