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 28, 2012	2012_168202_0019	T-1476-12	Complaint

Licensee/Titulaire de permis

HUNTSVILLE LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

MUSKOKA LANDING
65 ROGERS COVE DRIVE, HUNTSVILLE, ON, P1H-2L9

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): November 14, 15, 2012 (Facility) and November 19, 21, 23, 28, 2012 (Office)

During the course of the inspection, the inspector(s) spoke with Administrator, Co-Director of Care, Restorative Care Coordinator, Food Services Supervisor, Head Cook, Registered Nursing Staff, Personal Support Workers, Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, observed dining and snack services, reviewed the planned approved menu for week #4, reviewed pureed recipes, reviewed clinical records

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Food Quality
Nutrition and Hydration
Personal Support Services
Snack Observation

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. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all menu items are prepared according to the planned menu. [s.72.(2)(d)]

On July 04, 2012 during the dinner meal resident #001 aspirated and had to be sent immediately to the hospital. Staff interviews and clinical record review revealed that resident #001 choked on "chunks of food in the pureed meal". [S.72.(2)(d)]

Resident #004 and resident #005's plan of care identifies these residents as high risk for choking and require a pureed textured diet. On July 16, 2012 staff interviews and record review indicate that resident #004 and resident #005 found chunks of potatoes in their mashed potatoes.[s.72.(2)(d)]

On November 14, 2012 the planned approved dinner menu offered pureed turnip and pureed seasoned spinach. During the meal observation the inspector observed the pureed turnip and the pureed seasoned spinach served watery and runny by dietary staff and personal support workers were observed using paper towels on each resident plate to soak up the excess water. The recipe for Pureed Turnip states "pureed foods should be prepared to achieve a Pudding Consistency".

On November 15, 2012 the planned approved breakfast menu offered pureed muffin. Inspector observation revealed that the pureed muffin was glue like in texture and staff were unable to feed the pureed muffin to residents. The recipe for Pureed Muffin states "the finished product should be the consistency of whipped potatoes/mousse".

An interview with the head cook revealed that pureed muffins are to be pureed with water. The recipe for puree muffins states "use milk if needed to get the product to puree-do not add water".
Direct care staff interview revealed that textured foods are served inconsistently and pureed foods have been found to have chunks. [s. 72. (2) (d)]

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 menu items are prepared according to the planned menu, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques including safe positioning are used to assist residents that require assistance with eating. [s.73.(1)10]

Resident #003's plan of care identifies this resident as requiring total feeding assistance. On November 15, 2012 at 08:45 hours during breakfast service a Registered Practical Nurse (RPN) was observed to be standing and feeding resulting in resident #003 being in an unsafe position to accept food and fluids. [s. 73. (1) 10.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed no later than one business day after an injury has occurred in respect of which a person is taken to hospital. [s.107. (3) 3].

On July 04, 2012 at 18:23 hours resident #001 aspirated in the dining room and was immediately sent to hospital for further assessment. Staff interviews and clinical records reveal that the Director was not informed of resident #001's injury that resulted in resident #001 being taken to hospital. [s. 107. (3)]

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Issued on this 30th day of November, 2012

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