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

Division de la responsabilisation et de la performance du système de santé
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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
Mar 14, 2013	2013_190159_0009	H-000090-13	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

PEEL MANOR
525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9

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

ASHA SEHGAL (159)

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): February 28, March 5, 2013

During the course of the inspection, the inspector(s) spoke with with the Administrator, Nurse Supervisor, Registered Nurse, Registered Practical Nurse, Food Service Manager, personal care workers, dietary aides and residents.

During the course of the inspection, the inspector(s) observed noon and breakfast meal service, reviewed medical records and plans of care for identified residents and reviewed policies and procedures of the home.

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

Nutrition and Hydration

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 did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care. [s.6 (7)]

The plan of care related to nutritional care dated as reviewed March 2013 for resident # 2 directs staff to supplement the resident's intake with 1 box of nutritional supplement if resident's intake is less than 50% at all meals. During the breakfast and lunch meal on a specified date March 2013 it was observed that resident consumed less than 50% of the meal served. The staff did not supplement resident's meal with nutritional supplement as required in the plan of care. The electronic food and fluid intake records completed in Point Of Care (POC) did not reflect that nutritional supplement was provided or consumed by the resident. The resident was deemed high nutritional risk, had a significant unplanned weight loss.[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 of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with. [s. 8(1) b]
The home's Documentation Electronic –Health Record (LTC 09-05.11.06) policy was not complied with. The policy required that Personal Support Worker (PSW) accurate document care tasks at the time they are completed, at regular intervals throughout the shift. This policy was not complied with in relation to the following:

February 2013 on a specified date the noon meal was observed in a dining room. Resident # 2 was served a meal that consisted of 125 ml soup, 125 ml water, 125 orange juice, milk 125 ml, minced hot turkey, and a slice of bread. The resident was observed to consume ½ glass of orange juice, few sips of milk and ¼ serving of soup. However, the food and fluid intake documented in the electronic health record indicated that the resident consumed 51-75% of the meal and 375 ml fluids, which was not accurate of intake of the resident. Discrepancies were noted in the documented food and fluid intake and the amounts of fluids and food consumed by the resident.
March 2013 on a specified date during the breakfast meal resident #2 was served 125 ml water, orange juice, milk, hot cereal, tea, minced sausages and 2 halves of toast without crust. The resident consumed only ¼ cup of hot cereal, ½ glass of orange juice and a cup of tea. Resident did not eat any other of the food provided. The food and fluid intake record completed by staff in the electronic health record indicated that resident consumed 76-100% of the meal and 500 ml fluid. The intake of the meal and the fluids recorded was not accurate and did not reflect food and fluids consumed by the resident. The home's policy was not complied with in relation to accurate documentation of food and fluids intake of resident. [s. 8. (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, 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:
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. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the dining and snack service included, providing residents with any eating aides, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, in relation to the following: [73(1)9]
During the noon meal on a specified date February 2013 it was noted that resident #5, was not eating the food that was provided. Resident was trying to scoop the pureed food off the plate but was unable to do. The plan of care stated that the resident has difficulty getting all food so staff needs to assist. The staff was noted to be sitting at the table assisting another resident, however, staff did not provide assistance or encouragement to the resident. After a lengthy period of time (approximately 35 minutes) the registered practical nurse noted that the resident was not able to self-feed, fed resident two spoonful of pureed food and walked away. Staff did not provided assistance and/or encouragement for this resident to eat and as a result the resident consumed an inadequate amount of food during this meal.

Resident # 2 was in the dining room on a specified date March 2013 during the breakfast and was noted to not be eating the food that was provided. Beverages i.e milk, orange juice, water, tea and the hot cereal in a plastic cup were served to the resident. The staff was not readily available to provide assistance for the resident. After 10 minutes noted a registered practical nurse placed a glass of orange juice in resident's hand and staff person left the table. Resident consumed only few sips of juice. Staff returned to the resident at a later time and noted resident did not drink the juice and placed a cup of hot cereal in resident's hand and walked away. Staff did not provide any further encouragement or assistance for this resident to eat. A staff person was noted sitting at the table assisting another resident, however, staff did not provide encouragement or assistance for this resident. Resident sat with the food in front at the table for a lengthy period of time with no encouragement or assistance with eating. The plan of care identified that staff need to constantly supervise and assist resident during meals.
During the breakfast meal resident # 3 was observed head down, eyes closed holding a glass of milk in hand and a bowl of hot cereal in front. The resident was left unattended with no assistance for approximately 15 minutes. The plan of care stated staff to provide constant encouragement. Resident required significant encouragement and cuing but staff did not provide assistance or encouragement for this resident. [s. 73. (1) 9.]

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 dining and snack service included, providing residents with any eating aides. Assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

Issued on this 2nd day of April, 2013

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