Ontario

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
Oct 19, 24, 25, 26, 31, Nov 7, Dec 6, 2011	2011_063165_0024	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

RIVERSIDE GLEN LONG TERM CARE FACILITY
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

TAMMY SZYMANOWSKI (165)

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, registered staff members, personal support workers, dietary aides, food service supervisors, assistant general manager, general manager, and family members related to complaint inspection H-001429-11 and H-001558.

During the course of the inspection, the inspector(s) reviewed clinical health records, observed meal service, reviewed food production, and observed care.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Dining Observation

Personal Support Services

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The plan of care did not set out clear directions to staff and others who provide direct care to the residents.
An identified resident's cardex personal care profile indicated for staff to provide a tub bath and shower Monday and Friday, however, the plan of care updated August 13, 2011 indicated the resident's preference was to have a tub bath twice weekly per bathing schedule. The bathing schedule for October 17-23, 2011 indicated for staff to provide a shower Monday and Thursday.
An identified resident's personal care profile indicated for staff to provide a tub bath and shower Tuesday and Thursday, however the hygiene and bathing plan of care updated August 3, 2011 indicated for staff to provide bathing on Monday and Thursday a.m as per bathing schedule. The bathing schedule for October 17-23, 2011 indicated a tub bath on Tuesday and Thursday a.m.
An identified resident's cardex personal care profile indicated for staff to provide a tub bath on Thursday however, the plan of care updated August 27, 2011 indicated for staff to provide a bath or shower two times per week. The bathing schedule for October 17-23, 2011 indicated that the resident was only scheduled for a tub bath on Thursday.
An identified resident's cardex personal care profile indicated for staff to provide a tub bath on Wednesday, Thursday and Sunday, however the plan of care updated September 25, 2011 indicated for staff to provide a tub bath two times per week per bathing schedule. The bathing schedule for October 17-23, 2011 indicated the resident was scheduled for a tub bath Wednesday and Saturday a.m.
An identified resident's cardex personal care profile indicated for staff to provide a tub bath on Saturday however, the plan of care indicated for staff to provide a shower two times per week. The bathing schedule for October 17-23, 2011 indicated the resident was scheduled for a bath Tuesday and Friday p.m.
An identified resident's personal care profile indicated for staff to provide a shower on Monday and Thursday however, the plan of care updated August 2, 2011 indicated the resident's preference was to have a tub bath two times per week as per bathing schedule. The bathing schedule for October 17-23, 2011 indicated the resident was scheduled for a bath Monday and Thursday a.m.
An identified resident's cardex personal care profile indicated for staff to provide a tub bath Thursday and Sunday pm however, the plan of care updated September 16, 2011 indicated that the resident prefers to have shower twice weekly per bathing schedule. The bathing schedule for October 17-23, 2011 indicated for staff to provide a tub bath Thursday and Sunday p.m.
An identified resident's cardex personal care profile indicated for staff to provide a shower Wednesday and Sunday a.m. however, the plan of care updated October 22, 2011 indicated that the resident prefers to have a tub bath twice weekly per bathing schedule. The bathing schedule for October 17-23, 2011 indicated for staff to provide a tub bath Wednesday and Sunday a.m.

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 a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

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.
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.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
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 did not ensure that the Director was informed when a person was taken to hospital with an injury, no later than one business day after the occurrence. Two identified residents sustained falls in 2011 and required a transfer to hospital. The Director did not receive notification of the injuries in respect to the residents being taken to hospital. The Assistant General Manager confirmed that the home did not submit a critical incident report to the Director in both incidents.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
An identified resident stated they do not get two baths per week. The resident stated they are unaware when they are to receive their baths and would like to have two baths per week as they were used to having a shower every day. The Resident Care Monitoring and Observation Record for this resident indicated that the resident only received one bath the week of September 12-18, 2011, September 26-Oct 2, 2011 and October 3-10, 2011. The records indicated that the resident refused a bath the week of September 19-25, 2011 and did not receive another bath during that week. The resident's plan of care only indicated one tub bath on Saturday and the resident prefers to have a shower twice per week.
An identified resident stated that they do not receive two baths per week and that the equipment used hurts and therefore, will often refuse to be bathed. The resident indicated that the private duty person will provide a sponge bath. The Resident Care Observation and Monitoring Records for this resident did not indicate that the resident was offered a bath two days per week from August 1-October 23, 2011 with the exception of two occasions during the week of October 17-23, 2011 and one occasion the week of September 26-October 2, 2011 at which time the resident refused. The resident's plan of care indicated for staff to provide a tub bath however it did not specify days/times.
An identified resident stated that they only want one bath per week as they get too tired to have more than that however, the Resident Care Observation and Monitoring Records for this resident did not indicate the resident was offered at least one bath per week from September 26- October 23, 2011. The plan of care indicated for staff to provide a tub bath Thursday a.m. and for the resident to receive physical help in part of the bath or shower twice per week throughout the quarter.
An identified resident stated that there has been two occasions recently when they did not get two baths and they went six days without a bath. The resident indicated that they were told there were not going to be any baths tonight because there were not enough staff. The resident stated that staff do not make up the missed baths. Personal support workers confirmed that if the home is short staffed they pull the bath nurse to cover the regular shift and then the residents do not get their bath. The Assistant General Manager confirmed that the home pulls the bath shift to cover shortages in staff but the expectation is that baths are still completed. This resident's Resident Care Observation and Monitoring Records indicated that the resident did not receive a bath between September 20-27, 2011 and September 30-October 7, 2011.
An identified resident's Resident Care Observation and Monitoring Records indicated that the resident only received one bath the weeks of September 26-October 2 and October 10-16, 2011 and no baths the week of October 17-23, 2011. The resident's plan of care indicated for staff to provide a tub bath on Wednesday and Sunday a.m.
An identified resident's Resident Care Observation and Monitoring Records indicated the last documented bath provided by staff was September 30, 2011. There was no indication on the record that baths were provided for the weeks of October 3-9, 2011 and October 10-16, 2011.

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of,
(a) purchases relating to the food production system, including food delivery receipts;
(b) the approved menu cycle; and
(c) menu substitutions. O. Reg. 79/10, s. 72 (4).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality.
Residents interviewed indicated that the meat is tough, overcooked and often dry; vegetables are undercooked and still hard; and fresh seasonal foods are not always provided. Menu substitutions indicated that seedless grapes were substituted for canned fruit cocktail and fresh strawberries were substituted with frozen strawberries.
Several residents indicated that the home often runs short of menu items. The home ran short of the fish entree at the dinner meal in the Arthur home area October 26, 2011. The dietary aide called another home area for extra however, there was no fish available. The food service supervisor confirmed that the home did not have a formal tracking system for food shortages.
Residents indicated that the menu does not always reflect what is being served. Menu items to accompany entrees listed on the menu are often missing (cranberry sauce, mint jelly, and plum sauce).
2. The home did not ensure that the food production system must, at a minimum provide for documentation on the production sheet of any menu substitutions. The home currently documents menu substitutions on the week at a glance menu and no changes are made to the staffs production sheets.
3. The licensee did not maintain, and keep a record of the menu substitutions for at least one year.
The food service supervisor confirmed that the home did not keep copies of the menus on a regular basis where they identified menu substitutions.

Issued on this 7th day of February, 2012

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