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

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
Feb 14, 2014	2014_347197_0002	O-000042-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

HALLOWELL HOUSE
13628 LOYALIST PARKWAY, PICTON, ON, K0K-2T0

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 12 & 13, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, the Resident Services Clerk, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a member of the housekeeping staff, the Registered Dietitian and residents.

During the course of the inspection, the inspector(s) reviewed a resident's health care record, a critical incident report, the home's internal investigation file, 2013 mandatory education topics and attendance sheet, powerpoint presentations related to safe eating assistance and nutrition and culinary services and observed two lunch meals.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
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 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 has failed to comply with O. Reg. 79/10, s. 73(1)10. The following evidence shows that proper techniques and safe positioning were not used to feed a resident who requires feeding assistance.

The current plan of care indicates that resident 1 requires feeding assistance and gives specific instructions related to the safe positioning of the resident.

It was reported by staff members that during a meal service staff member S100 fed resident 1 at a very fast pace and did not have the resident properly positioned for feeding. Staff member S100 confirmed that he/she did not properly position resident 1 for the specified meal.

During the inspection, inspector #197 observed two meals where staff member S100 was feeding resident 1. Improper feeding techniques were observed during both meals.

During one meal service that was observed by the inspector the Registered Dietitian for the home was touring the dining room. When asked, the Registered Dietitian stated the pace of the feeding was a bit fast and may not allow sufficient time for the resident to swallow between spoonfuls. [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 and safe positioning are used to feed residents who require assistance, to be implemented voluntarily.

WN #2: 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 has failed to comply with LTCHA 2007, s. 6 (7). The following evidence shows that the care set out in a resident's plan of care was not provided as specified in the plan.

Resident 1's current plan of care gives specific instructions to position the resident for safe eating.

On a specified date, resident 1 was not positioned for safe eating as per the care plan instructions.

Resident 1's current plan of care related to communication states that staff are to communicate to the resident all care being done prior to starting and throughout procedures.

The Executive Director for the home indicated that the expectation during meals would be for staff to communicate to resident 1 that they are starting the meal before they begin.

During dining observation on two different days inspector #197 observed staff member S100 to feed resident 1. Staff member S100 did not communicate to the resident at the beginning or during either meal. [s. 6. (7)]

Issued on this 6th day of March, 2014

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

Jessica Pattin, RD