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
Nov 5, 6, 7, 9, 2012	2012_190159_0003	Other

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

THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8

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

ASHA SEHGAL (159), BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

During the course of the inspection, the inspector(s) spoke with General Manager, Food Service Supervisor, Registered Staff, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) conducted a tour of the home areas, observed the noon meal service, reviewed residents health records, policies and procedures, and Residents Council minutes. A Joint Hamilton Service Area Office Initiated inspection was conducted by Dietary and Environmental Inspectors. (Log# H-002121-12)

The following Inspection Protocols were used during this inspection:

Dining Observation

Residents' Council

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. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. [LTCHA 2007, c. 8., s. 85(3)] The licensee failed to ensure that the advise of the residents' council was sought in developing and carrying out the survey and in acting on its results.

Interviews with the representative of Residents' Council and the Administrator confirm that Resident Council was not consulted in the development and carrying out of the satisfaction survey and in acting on its results.

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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

[O.Reg. 79/10, s. 8(1)(b)] The Licensee did not ensure that were the Act or this Regulation requires the licensee to have, institute or otherwise put in place any policies, procedures or strategies, that those policies, procedures or strategies are complied with, in regards to following:
The home's policy (Fall Incident Report Form - dated October 2011) directs staff to complete a post fall assessment and analysis of falls occurring within a 24 hour period. The documented progress notes identified that a resident # 5 had a fall and does not contain a post fall assessment for this incident. On November 6, 2012, Registered Staff and the Administrator confirmed that a post fall assessment was not completed. This policy was not complied with in relation to post fall assessment and analysis of fall within a 24 hour period.

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 subsections:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. [O. Reg. 79/10, s.73(2)(b)] The licensee did not ensure that,

(b) a resident who requires assistance with eating or drinking is not served a meal until someone is available to provide the assistance required by the resident.

During a lunch meal on November 6, 2012, residents #001 and #002 who required extensive assistance with eating (as specified in their plan of cares) were served their first course (soup) prior to someone being available to provide assistance. Resident #002 received soup and then did not get assistance for approximately 7-9 minutes. Resident #001 attempted to self feed but could not manipulate the spoon well and spilled a lot of the soup onto their meal apron. The resident then attempted to drink from the soup bowl and was observed by a staff member who approached the resident and told them to use their spoon and then walked away. The resident did not receive any assistance for the first course.

WN #4: 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. (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. [LTCHA 2007, S.O. 2007, c.8, s. 6(7)] 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.

During the noon meal on November 6, 2012, residents #003 and #004 received thickened fluids with the consistency of pudding. The plan of care and the attending physician's diet orders specify that both resident #003 and #004 are to receive nectar thickened fluids. A staff member was observed hand pouring thickener powder from a container into resident's beverage glasses. No measuring tool was used and directions were not followed to prepare variable consistencies of thickened fluids required for these residents. During the meal service, resident #004 was observed using a spoon to consume their thickened milk and resident #003 tried to pour milk into their coffee and couldn't because the milk was stuck to the glass.

Issued on this 9th day of November, 2012

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

B. Lucuik Ab Selak