Ontario

Ministry of Health and Long-Term Care / Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007 / Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 12, 2019	2019_573581_0008	027492-18	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

West Oak Village
2370 Third Line OAKVILLE ON L6M 4E2

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

DIANNE BARSEVICH (581)

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): July 3, 4, 5 and 8, 2019.

**The following complaint inspection was completed:
log #027492-18 - related to housekeeping and communication.**

During the course of the inspection, the inspector(s) spoke with Acting Executive Director, Regional Manager, Director of Care (DOC), Associate Directors of Care (ADOC), Registered Nurse (RN), Registered Practical Nurses (RPN), Nutrition Manager, Environmental Service Manager (ESM), Personal Support Workers (PSW), Dietary Aides (DA), Light Duty Cleaner, Laundry Aide, private care giver and residents.

During the course of the inspection, the inspector: toured the home, reviewed resident health records, complaint letters and responses, policies and procedures and observed residents and the provision of care.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Nutrition and Hydration
Personal Support Services**

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint log #027492-18, was submitted to the Director on and identified day in October 2018, related to housekeeping and communication concerns.

Review of the clinical health record identified resident #001 was to receive specific nutritional interventions at meals.

On two identified days in July 2019, resident #001 was observed in the dining room and did not receive their specific interventions with their meal.

In an interview on an identified day in July 2019, with an external outside service provider they stated the resident did not receive their nutritional intervention.

During an interview on an identified day in July 2019, with Dietary Aide #111, they reviewed the resident's diet plan on the menu stream computer which identified resident #001 was to receive both items at meals and confirmed they did not receive their specific nutritional interventions at meal service.

The care set out in the plan of care was not provided to resident #001 as specified in the plan related to nutrition. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care

reviewed and revised at any other time when the resident's care needs changed or care set out in the plan of care was no longer necessary.

Review of the clinical health record identified that resident #001's substitute decision maker (SDM) requested on an identified day in March 2018, that care would not be provided by specific staff.

On an identified day in July, 2019, resident #001 was observed being transferred to the toilet by specific staff.

During an interview with PSW #108 they stated they were unaware they were not to provide care to resident #001. They said they had provided care in the past with the resident's SDM present and no concerns were raised.

In an interview with resident #001's SDM they stated they did not recall making the request related to specific staff and did not have any concerns. They stated they were aware that care was provided to resident #001 by PSW #108 and had no issues.

During an interview with ADOC #002, they confirmed the plan of care was not reviewed and revised when the care set out in the plan was no longer necessary related to care not being provided to resident #001. [s. 6. (10) (b)]

Issued on this 12th day of July, 2019

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

Original report signed by the inspector.