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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 22, 2016	2016_414110_0002	T-2837-15	Critical Incident System

Licensee/Titulaire de permis

FRIULI LONG TERM CARE
7065 Islington Avenue Woodbridge ON L4L 1V9

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

VILLA LEONARDO GAMBIN
40 Friuli Court Woodbridge ON L4L 9T3

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

DIANE BROWN (110)

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 5, 10 and 11, 2016.

During the course of the inspection, the inspector(s) spoke with Administrator, nurse champion, registered nurse (RN), Registered practical nurse (RPN), personal support worker (PSW).

During the course of the inspection the inspector reviewed the resident's health record and staff schedules.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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	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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001's written care plan identified him/her at high risk for safe oral intake. The resident's care plan identified nutritional goals to achieve oral intake in the amount the resident feels comfortable consuming and for staff to not strongly encourage oral intake - allowing the resident to refuse food and fluids.

Written plan of care interventions related to eating directed staff to provide total feeding; one staff to feed all foods and fluids without resident participation. Feed slowly to minimize risk of aspiration, use of an identified assistive feeding device during meals and that the SDM brings additional food to supplement resident's intake. Interventions also included direction to position resident at a 90 degree angle and for the staff to reinforce the resident should eat slowly.

Staff interviews with RPN #104, PSW's #105 #106 and #107 revealed the resident's SDM was concerned about resident's intake, the resident losing weight and often and persistently fed the resident.

On an identified date and time resident #001 had a choking episode. An interview with PSW #101 revealed that he was serving evening nourishments with two other PSW's when he heard a call for help from the hallway outside the activity room. Personal support worker #101, assigned to resident #001 entered the activity room where resident was observed in distress and obviously choking. Staff #101 initiated the Heimlich maneuver then RN #110 began to suction the resident. Resident was transferred to the hospital and died a few days later.

Interviews with staff PSW's #101 and #107, along with RN's #108 and #110, on site at the time of the incident, stated the resident, SDM and another family member were alone in the activity room, where SDM had been feeding the resident.

Observations of the entrance and layout of the activity room and location of the resident at the time of the incident revealed that resident #001 was not in view from the hallway while being fed by the SDM.

An interview with RN #110 revealed the resident's SDM often fed resident alone in the activity room.
Registered nurses #108 and #110 along with PSW #101 were unaware if resident had been safety positioned, fed slowly, provided the appropriate diet texture and/or allowed to refuse food and fluids according to the plan of care.

An interview with the Director of Care confirmed that staff should have been close by to ensure that those feeding are following the recommendations in the plan of care and that staff would provide re-education to an individual if necessary. [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 was provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 22nd day of February, 2016

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

Original report signed by the inspector.