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
Nov 5, 2013	2013_201167_0031	H-000335-13, H-000508-13	Complaint

Licensee/Titulaire de permis

PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE
72 Town Centre Drive, Townsend, ON, N0A-1S0

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

GARDENVIEW LONG TERM CARE HOME
72 Town Centre Drive, Townsend, ON, N0A-1S0

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

MARILYN TONE (167)

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): October 21, 22, 24, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), the Assistance Director of Care (ADOC), registered nursing staff and personal support worker staff and the identified residents.

During the course of the inspection, the inspector(s) conducted a review of the health files for the identified residents, reviewed relevant policies and procedures, reviewed any investigation notes completed by the home, observed resident care and medication administration for an identified resident.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Pain

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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that fluids were served to resident # 002 at a temperature that was both safe and palatable to the resident.

A) On an identified date in 2013, resident # 002 sustained an injury related to having spilled their hot coffee onto themselves.
B) The resident did not require hospitalization but the resident did sustain a burn.
C) The progress notes for the resident indicated that the resident's health condition could have put them more at risk for spilling.[s. 73. (1) 6.]

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 fluids served to residents who are at risk for spilling are served at a temperature that is both safe and palatable to the residents, 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:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was immediately informed that the home was experiencing an outbreak of a communicable disease.

A) During a review of the report sheets located at the nurses' station on one home area for an identified month in 2013, it was noted that on on an identified day, at least six residents were experiencing symptoms of respiratory infection. One day later, a seventh resident was added to the line list. One day after that, an eighth resident was added to the line list. Two days following that, a ninth resident was added to the line list. There were 31 resident located on the identified home area.
B) The home did not report the respiratory outbreak to the Director until one day after the ninth resident was added to the line list when it was brought to the attention of the Director of Care by the Long-Term Care Homes Inspector that the outbreak had not been reported to the Director.
C) The Director of Care indicated that she was not aware that outbreaks when identified had to be immediately reported to the Director. [s. 107. (1) 1.]

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 when the home experiences an outbreak of communicable disease that it is reported immediately to the Director., to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee did not ensure that staff and others involved in the care of the resident collaborated with each other in the development and implementation of the plan of care so that different aspects of care were integrated and consistent with one another.

A) It was noted that on an identified date in 2013, resident # 002 sustained a burn related to having spilled their coffee.
B) During an interview with the staff member who had distributed the coffee on the identified day when the resident sustained the burn, it was confirmed that the resident was seated at a table in the dining room when they spilled the coffee. During the interview with the staff member, they indicated that the resident did not appear drowsy when they provided the coffee to the resident. Staff interviewed confirmed that the resident usually drinks the coffee and eats independently with minor supervision and encouragement. It was noted that the resident does not like to be fed and prefers to feed themselves.
C) During a care conference on an identified day after the incident occurred, the documentation indicated that a special mug would be provided for the resident to prevent spills and that ice cubes would be placed in the resident's coffee prior to serving it to them.
D) It was noted that the document that the home refers to as the care plan under the section related to eating was updated to include this information.
E) During interviews with personal support worker staff at the home, they all confirmed that they place ice cubes in the resident's coffee prior to serving it to the resident. None of the personal support worker staff interviewed were aware of the identified use of a special mug to prevent spills.
F) It was noted that the mug was never provided for the resident to use but the care plan still included the requirement to use this mug for the resident's coffee.
G) During an interview with the Food Services Supervisor, it was noted that they were not aware of the burn sustained by the resident or the use of a special mug to prevent spills or the need to place ice cubes in the resident's coffee prior to serving it.
H) The dietary notes for the resident located in the servery area did not include any information related to the use of a special mug or the placement of ice cubes to the resident's coffee.

Staff at the home did not collaborate with each other so that the different aspects of eating were integrated and consistent with one another. [s. 6. (4) (b)]

Issued on this 6th day of November, 2013

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