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
Aug 21, 2013	2013_122156_0016	H-000275-13	Complaint

Licensee/Titulaire de permis

HALDIMAND WAR MEMORIAL HOSPITAL
206 JOHN STREET, DUNNVILLE, ON, N1A-2P7

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

EDGEWATER GARDENS LONG TERM CARE CENTRE
428 BROAD STREET WEST, DUNNVILLE, ON, N1A-1T3

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

CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 13, 14, 15, 2013

This inspection is in relation to H-000275-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Dietitian (RD), and Nutrition and Environmental Supervisor

During the course of the inspection, the inspector(s) reviewed the resident's clinical record including progress notes, assessments, care plan, and weight history.

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

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The registered dietitian who is a member of the staff of the home failed to complete a nutritional assessment for the resident whenever there was a significant change in the resident's health condition. The RD failed to complete a nutritional assessment for resident #001 despite several notations regarding difficulty swallowing and/or pocketing food over a five month period.
A swallowing assessment was completed for resident #001 in September 2012 where feeding recommendations were made and the resident remained on regular fluids and textured solids.
According to the progress notes, there were 8 times when it was noted that the resident was having difficulty swallowing and/or pocketing food from January 2013 until mid-May 2013.
Progress notes indicated the resident was having difficulty swallowing and/or pocketing food twice in January and twice in February 2013. The dietary quarterly review was completed on mid-February, 2013, however, there was no mention of any swallowing or pocketing of food issues. Further progress notes in April and May, 2013 indicated the resident was having difficulty swallowing and/or pocketing food. A dietary referral was made in May, 2013 and the resident was seen by the RD. It was noted that the resident was not always swallowing and that swallowing had declined this quarter, however, another swallowing assessment was not initiated during this time. The RD confirmed on August 14, 2013 that a swallowing assessment was not initiated. [s. 26. (4)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter. As confirmed by the RD and Nutrition and Environmental Supervisor on August 14, 2013, Resident #001 did not have a monthly weight taken and recorded in February and April, 2013. The plan of care for this resident did not indicate that the weight was not to be taken monthly. [s. 68. (2) (e) (i)]

Issued on this 21st day of August, 2013

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

Carol Polez, RD.