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 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
Jul 31, 2015	2015_347197_0025	O-002089-15	Follow up

Licensee/Titulaire de permis

AON INC.
33 HARBOUR SQUARE SUITE 825 TORONTO ON M5J 2G2

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

MOIRA PLACE LONG-TERM CARE HOME
415 RIVER STREET WEST TWEED ON K0K 3J0

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 28, 29, 30, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, a Registered Practical Nurse and Personal Support Workers.

The inspector also observed three lunch meals and reviewed the following: resident health care records, dining room audits, updated dining policies/procedures, the meal documentation form, staff training related to dining service and CQI/Management Committee Meeting Minutes from July 2015.

The following Inspection Protocols were used during this inspection:
Dining Observation

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 73. (1)	CO #001	2015_270531_0010	197

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 has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in a resident's plan of care was not provided as specified in the plan.

Resident #2's care plan dated July 2015 states that staff are to offer liquids (one at a time) or solids but not both together as the Resident will mix them and then will not eat. The care plan goes on to say that if the Resident is mixing foods then offer one item at a time starting with meat/alternatives.

Lunch observation was completed on a specified home area on July 28, 29 and 30, 2015. On July 29, 2015, Resident #2 was observed to get soup and an entree at the same time. The Resident mixed some of the entree into the soup but did continue to eat. Once the Resident had completed the soup, entree and dessert, a Personal Support Worker (PSW) provided the Resident with two drinks, a glass of milk and a glass juice. The Resident then poured the juice into the milk. A PSW then came by and removed the empty milk glass and did not seem to notice what the Resident had done. The Resident was then provided a second dessert, which the Resident did eat, but then poured the remainder of the mixed drink into the dessert bowl. At this point a PSW did offer another drink, but Resident #2 declined.

Staff did not follow Resident #2's care plan during the lunch meal on July 29, 2015. [s. 6. (7)]

Issued on this 31st day of July, 2015

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

Original report signed by the inspector.