Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 19, 20, Oct 1, 2012	2012_108110_0018	Follow up

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

COLEMAN CARE CENTRE
140 CUNDLES ROAD WEST, BARRIE, ON, L4N-9X8

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 Follow up inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Food Service Supervisor, Food Service workers and Residents.

During the course of the inspection, the inspector(s) Reviewed resident health records; observed meal service.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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
(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).

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 did not ensure staff and others involved in the different aspects of care collaborate with each other in the development and implementation of resident #2's plan of care.
Resident #2's plan of care identifies him/her at high nutritional risk. The Registered Dietitian's assessment of June 1st, 2012 resulted in the implementation of a nutrition intervention for weight maintenance. The Food Service Supervisor revealed during an interview that the intervention was incorrectly transcribed to front line staff. Resident #2 continued to lose weight. Resident #2's May 2012 weight was recorded as 41.1kg and his/her September 2012 weight was 38.1kg.[s. 6. (4) (b)]
2. The licensee did not ensure that the care set out in Resident #2's plan of care was provided to the resident as specified in the his plan.
Resident #2's plan of care identifies him at high nutritional risk. This identified resident is underweight with a BMI of 15. The Registered Dietitian's assessment of Resident #2 on June 12th, 2012 confirmed this resident's ongoing need for an intervention of food and implemented a new fluid intervention to maximize intake.
Observations of Resident #2 at lunch on September 19th, 2012 and breakfast on September 20th, 2012 revealed that the Registered Dietitian's interventions of June 1st and June 12th, 2012 were not practiced. Dietary staff interviewed did not state an awareness of the required interventions for this resident. Resident #2 continued to lose weight. Residents' May 2012 weight was recorded as 41.1kg and his/her September 2012 weight was 38.1kg.[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 nutritional care set out in residents' plan of care is provided and that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of residents' plan of care., to be implemented voluntarily.

Issued on this 5th day of October, 2012

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

Diane Brown