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
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
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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
Jul 17, 2013	2013_200148_0023	O-000526-13	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

FOREST HILL
6501 CAMPEAU DRIVE, KANATA, ON, K2K-3E9

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

AMANDA NIXON (148)

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): June 24 and 25, 2013, on site.

The inspection relates to Critical Incident Report # 2834-000021-13

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistant Director of Care (ADOC), Nutritional Manager, Registered Dietitian, Registered Nursing Staff, Personal Support Workers (PSW) and Activity Staff Member.

During the course of the inspection, the inspector(s) reviewed the identified resident's health care record, including plan of care, assessment and monitoring documentation. The inspector also reviewed the diet list at point of meal service, the nursing shift to shift communication book and the Winter/Spring menu, including production sheets for June 14, 2013 and menu approval. In addition, the lunch meal service of June 24, 2013 was observed.

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

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 O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 26 (3) 13., in that the licensee did not ensure that the plan of care was based on an interdisciplinary assessment of the resident's nutritional status including any risks relating to nutritional care.

A progress note on a specified date, written by Registered Practical Nurse (RPN) Staff Member #104 indicates that Resident #1 had a choking incident that required nursing intervention.

A progress note on another specified date, written by RPN Staff Member #104 indicated that Resident #1 was having difficulties with eating a meal. The note indicated that a PSW staff member reported to Staff Member #104, that the resident has been having difficulties with swallowing food and coughing when drinking. Staff Member #104 indicated that a dietary referral would be completed.

RPN Staff Member #104 reported to Inspector #148 that in both of the instances above, it was decided to monitor the resident. When asked by Inspector #148, Staff member #104 confirmed that a dietary referral was not sent to the dietary department. Staff member #104 further reported that there was no communication to any other disciplines of either incident, as noted above.

PSW Staff Member #102 who cared for Resident #1 reported to Inspector #148 that he had witnessed the resident having difficulties with food, in which food would get caught in the resident's throat. Staff member #102 explained that Resident #1 would eat quickly and would cough at meals.

A progress note on a specified date, written by RPN Staff Member #106 indicated that Resident #1 was coughing and having difficulties with a meal. Staff Member #106 sent a referral to the dietary department due to concerns identified during the same meal, on the same date.

The next day, Resident #1 was consuming a meal when it was observed by a PSW Staff Member that the resident was choking and gasping for air. Chest thrusts and CPR were initiated. The ambulance was called and paramedics later reported to the home that the resident was pronounced dead by the hospital physician.

The Registered Dietitian reported to Inspector #148 that she was unaware of any choking incident or chewing/swallowing difficulties prior to the resident's death.

The Nutritional Manager reported to Inspector #148 that she was unaware of any choking incident prior to the resident's death.

The most current plan of care for Resident #1 includes that the resident requires a regular diet and texture. The plan of care also reflects the need for special interventions related to the resident's level of understanding related to the task of eating and drinking.

The plan of care did not include an interdisciplinary assessment of risks related to nutritional care specific to the resident's recent chewing/swallowing difficulties at meal times. [s. 26. (3) 13.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1)(c), in that the licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and other who provide direct care to the resident.

Interviews with Registered Nursing Staff Members, PSWs, Nutritional Manager and a Recreation Staff member (who has been responsible for feeding Resident #1) along with the Diet List and PSW Flow Sheets, indicates a variation of Resident #1's feeding assistance needs, including: that the resident can fed self and occasionally needed verbal or physical cues, that the resident fed self and only required monitoring, that the resident required extensive to total physical feeding assistance, that the resident didn't understand the use of utensils, that the resident preferred the use of utensils.

The most current plan of care for Resident #1 indicates that the resident prefers finger foods, that the resident will use utensils but requires physical assist, may require staff to feed.

The plan of care did not set out clear directions to staff related to Resident #1's need for feeding assistance. [s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (2), in that the licensee did not ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

PSW Staff Member #102, RPN Staff Member #104 and the home's Registered Dietitian reported to Inspector #148 that the resident was known to eat quickly and/or too fast.

There is no indication in the plan of care that the resident ate food quickly and/or too fast.

The plan of care did not reflect the current needs and preferences of Resident #1 related to eating quickly and/or too fast. [s. 6. (2)]

Issued on this 17th day of July, 2013

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

Amanda Nix RD LTCH Inspector

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2013_200148_0023
Log No. / Registre no:	O-000526-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 17, 2013
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	FOREST HILL 6501 CAMPEAU DRIVE, KANATA, ON, K2K-3E9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SARAH FERGUSON - MCLAREN

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall ensure that the plan of care for each resident is based on an interdisciplinary assessment of any risks relating to nutritional care, including chewing and swallowing problems.

Grounds / Motifs :

1. 1. The licensee failed to comply with O.Reg. 79/10 s. 26 (3) 13., in that the licensee did not ensure that the plan of care was based on an interdisciplinary assessment of the resident's nutritional status including any risks relating to nutritional care.

A progress note on a specified date, written by Registered Practical Nurse (RPN) Staff Member #104 indicates that Resident #1 had a choking incident that required nursing intervention.

A progress note on another specified date, written by RPN Staff Member #104 indicated that Resident #1 was having difficulties with eating a meal. The note indicated that a PSW staff member reported to Staff Member #104, that the resident has been having difficulties with swallowing food and coughing when drinking. Staff Member #104 indicated that a dietary referral would be completed.

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A progress note on a specified date, written by RPN Staff Member #106 indicated that Resident #1 was coughing and having difficulties with a meal. Staff Member #106 sent a referral to the dietary department due to concerns identified during the same meal, on the same date.

The next day, Resident #1 was consuming a meal when it was observed by a PSW Staff Member that the resident was choking and gasping for air. Chest thrusts and CPR were initiated. The ambulance was called and paramedics later reported to the home that the resident was pronounced dead by the hospital physician.

The Registered Dietitian reported to Inspector #148 that she was unaware of any choking incident or chewing/swallowing difficulties prior to the resident's death.

The Nutritional Manager reported to Inspector #148 that she was unaware of any choking incident prior to the resident's death.

The most current plan of care for Resident #1 includes that the resident requires a regular diet and texture. The plan of care also reflects the need for special interventions related to the resident's level of understanding related to the task of eating and drinking.

The plan of care did not include an interdisciplinary assessment of risks related to nutritional care specific to the resident's recent chewing/swallowing difficulties at meal times. [s. 26. (3) 13.] (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 07, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of July, 2013

Signature of Inspector / Signature de l'inspecteur : Amanda Nix

Name of Inspector / Nom de l'inspecteur : AMANDA NIXON

Service Area Office / Bureau régional de services : Ottawa Service Area Office