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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 4, 2016	2016_486653_0007	026123-16	Complaint

Licensee/Titulaire de permis

KRISTUS DARZS LATVIAN HOME
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

KRISTUS DARZS LATVIAN HOME
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

ROMELA VILLASPIR (653)

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): August 29 and 31, 2016.

This Complaint Intake was inspected related to not receiving a meal.

During the course of the inspection, the inspector reviewed resident's health records, diet list, dietary services tray request forms and staff schedules.

During the course of the inspection, the inspector(s) spoke with resident #001, the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Cook, Nutrition Manager (NM), and the Registered Dietitian (RD).

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (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 has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

During the Resident Quality Inspection (RQI), resident #001 indicated to Inspector #653 that the home did not provide a substitute for an identified food item upon his/her request.

During an interview, resident #001 indicated that he/she used to eat an identified food item but had recently become intolerant to it, and that registered staff were aware that the identified food item caused gastrointestinal upset.

Review of the progress note on Point Click Care (PCC) on an identified date, indicated that resident stated to RPN #102 he/she had the identified food item that day and the previous day, and that he/she spent all of his/her time in the washroom. Resident #001 stated to the RPN that he/she was intolerant to the identified food item.

Review of the progress note on PCC on an identified date, indicated that resident #001 ate the identified food item and complained of stomach ache to RPN #102. Subsequent documentations on the two identified progress notes did not indicate any follow up assessments on the concern brought forth by the resident to the RPN.

An interview conducted with RPN #102 stated that resident #001 was sensitive to the identified food item and that it caused gastrointestinal upset. The RPN further indicated he/she had verbally informed the Registered Dietitian (RD) and dietary staff of resident #001's sensitivity to the identified food item.

An interview conducted with Cook #104 stated that resident #001 had been refusing the identified food item and that he/she had been aware for a long time.

An interview with the home's RD stated that he/she was not aware of any concerns resident #001 had with regards to the identified food item. The RD further indicated that he/she did not receive a referral for resident #001 with regards to the identified food item.

An interview with the home's Nutrition Manager (NM) stated that he/she was aware that resident #001 had been refusing the identified food item, and further indicated that if nurses were aware that the identified food item caused resident to be sick, then a dietary referral should have been made in order for the RD to assess the resident and develop a resident specific menu.

There was no information obtained to indicate collaboration occurred between nursing and dietary department to address resident #001's sensitivity to the identified food item. [s. 6. (4) (b)]

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 staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be fed was fully respected and promoted.

During the RQI, resident #001 mentioned to Inspector #653 that he/she was not provided tray service on an identified date.

Interview with resident #001 confirmed that on the evening of an identified date, he/she had told the PSWs and RPN #103 that he/she was not feeling well and could not come down to the main dining room for dinner. Resident had asked RPN #103 for a tray service. Resident #001 stated that the tray service was not provided that evening.

Interview with RPN #103 confirmed that resident #001 did not receive a tray service that evening.

Review of the home's tray request form for dinner, on an identified date, did not indicate resident #001's name on the list.

Interview with the NM confirmed that resident #001's name was not listed on the tray request form for dinner on an identified date, and he/she further indicated that the order for the tray service was not placed. [s. 3. (1) 4.]

Issued on this 10th day of October, 2016

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

Original report signed by the inspector.