Ontario

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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 13, 2019	2019_755728_0015	013529-19	Critical Incident System

Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Lanark Heights Long Term Care Centre
46 Lanark Crescent KITCHENER ON N2N 2Z8

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

MARIA MCGILL (728)

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): July 30-31, 2019.

The following intakes were completed in this Critical Incident System Inspection:

Log #013529-19 related to an incident at a meal time which resulted in a significant change in the resident's health status.

Inspector, Katherine Adamski (753) attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Registered Dietitian, a Registered Practical Nurse (RPN) Team Lead, Dietary Aides, RPNs, and Personal Support Workers (PSW).

The inspector(s) reviewed clinical records and plans of care for relevant residents, and relevant home documentation.

Observations were conducted at meal times, of residents, and staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to ensure proper techniques to assist residents with eating, including safe positioning of residents who require assistance was implemented.

Resident #002 was observed to be in an identified position while being provided assistance with eating.

The plan of care identified that the resident required a certain level of assistance at meal times and that their positioning posed an identified risk. There were no interventions related to improving the resident's positioning documented in the resident's plan of care.

Manager of Resident Care #101 said that interventions should be documented in the care plan. RPN #108 said that staff referred to the care plan for resident care information.

The resident was observed to be in an identified position and began coughing. When staff intervened, their positioning was adjusted using a specified intervention.

Manager of Resident Care #101, PSW #102, RD #107, and RPN #108 stated that resident #002 was positioned in a specified way during meals because of identified concerns. RPN #108 said that a specified intervention was often used to keep resident #002 in a safer position for swallowing. RD #107 said that the identified intervention was often used because it kept the resident in a safer position for swallowing. Manager of Resident Care #101 said that staff have varying comfort levels when assisting resident #002 with feeding and all staff may not be comfortable adjusting resident #002's positioning.

PSW #102, RD #107, RPN #108, and RPN Team Lead #103 said that the best practice was for residents to be positioned at 90 degrees, sitting upright, for meals. Resident #002's plan of care did not identify interventions to support safer positioning.

The licensee failed to ensure proper techniques to assist residents #002 with eating, including safe positioning of the resident were implemented. [s. 73. (1) 10.]

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 proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

Issued on this 14th day of August, 2019

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

Original report signed by the inspector.