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

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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
Jan 9, 2014	2013_201167_0037	H-000412-13	Complaint

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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

MARILYN TONE (167)

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): December 12 & 18, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Administrator, registered staff, personal support workers (PSWs), the Nutrition Manager, residents and staff.

During the course of the inspection, the inspector(s) conducted a review of the health files for identified residents, reviewed relevant policies and procedures, observed meal service and observed care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee did not ensure that meals were served course by course to residents unless otherwise indicated.

A) During observation of the lunch meal on December 18, 2013, it was noted that desserts were being served to all residents at the same time, regardless of whether or not the resident had completed their main course.
B) It was noted that the main dessert for the lunch meal on December 18, 2013 was ice cream and at one table three residents were served their desserts when they were noted to be still eating their main course. At another table, three residents were served their desserts while the two staff members were still feeding them their entrees. It was also noted that in the second dining room on the extension wing, a resident's ice cream was served to them while they were still eating their soup course and they had not even started their main course. Fifteen minutes later, when the resident was done their main course, the resident's ice cream lay melted in the bowl.
C) It was also noted that the main entree was served to a number of residents prior the soup course being completed by the resident. [s. 73. (1) 8.]

2. The licensee did not ensure that assistance was provided to a resident who required assistance with eating or drinking prior to the meal being served to the resident.

A) The plan of care for resident # 004 indicated that staff must feed the resident, if not chokes easily.
B) Resident # 004 was seated at a table with two other residents. Residents # 003 and # 005 were seated on the other side of the table and both were identified in their plans of care to require total assistance with feeding.
C) During the lunch meal on December 18, 2013, it was noted that Residents # 004, # 003 and # 005 received their meals at approximately the same time but only Resident # 003 and # 005 received assistance with feeding by the one staff member assigned to the table.
D) It was noted that Resident # 004 was not eating but just stirring the food around with their spoon.
E) Approximately one half hour after the food was placed in front of Resident # 004, the PSW who had been feeding Residents # 003 and # 005 came to assist Resident # 004. [s. 73. (2) (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 a) meals at the home are served course by course to residents unless otherwise indicated and b) to ensure that residents who require assistance with eating or drinking receive that assistance prior to being served their meal., to be implemented voluntarily.

Issued on this 9th day of January, 2014

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