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
Jun 17, 27, Jul 25, 2011	2011_063165_0003	Critical Incident

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

RIVERSIDE GLEN LONG TERM CARE FACILITY
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the director of nursing care, the assistant general manager, and the nutrition manager.

During the course of the inspection, the inspector(s) reviewed the clinical health record and policies and procedures.

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Hospitalization and Death

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
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. (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 sayants :

An identified resident did not receive care set out in their plan of care. The resident received a regular diet texture for the lunch meal despite a physicians order that indicates the resident was to receive a therapeutic textured diet.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits sayants :

The home did not develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long term care home. The nutrition manager confirmed that the quality improvement and utilization review system was not implemented in the new home area and no formal monitoring was completed of meal service in order to analyze, evaluate and improve the quality of food service in the new home area.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits sayants :

The licensee did not ensure that where the act or this regulation requires the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure strategy or system, the licensee is required to ensure that the plan, policy protocol, procedure, strategy or system was in compliance with and is implemented in accordance with all applicable requirements under the Act.
Regulation 68(2)(a) indicates that every licensee of a long term care home shall ensure that the programs include, the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration. The Director of Care and the Nutrition Manager confirmed that the home did not have a policy and procedure developed and implemented related to a nutritional risk indicator when the critical incident occurred.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits sayants :

A critical incident occurred which resulted in the unexpected death of a resident. The licensee submitted a critical incident report however, the home failed to make the report using the Ministry's method for after hours emergency contact, since the incident occurred outside of normal business hours.

Issued on this 10th day of August, 2011

[redacted]

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