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
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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
Apr 23, 2014	2014_226192_0012	L-000405-14	Complaint

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

DEBORA SAVILLE (192)

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): April 14, 15, 16, and 19, 2014

This inspection was conducted concurrently with complaint inspection L-000398 -14 and follow-up inspection L-000401-14

During the course of the inspection, the inspector(s) spoke with residents, family, the Acting Director of Resident Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Registered Dietitian, and the Resident Assessment Instrument Quality Improvement (RAI QI) Coordinator.

During the course of the inspection, the inspector(s) reviewed medical records, schedules, policy and procedure, and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy on Weight and Height Monitoring was complied with.

The home's policy titled Weight and Height Monitoring signed as reviewed January 2013 identified that when there is a weight loss or gain of two kilograms or more the team lead will be notified. The team leader will complete the Request for Dietary Consult form, which will be given to the Director of Food services immediately and a copy will be given to the Registered Dietitian.

A review of the medical record for resident #002 identified that when weighed in a designated month in 2014 the resident had sustained a weight loss greater than two kilograms.

Interview with the registered staff, Resident Assessment Instrument, Quality Improvement (RAI QI) Coordinator confirmed that no Request for Dietary Consult had been completed for resident #002.

Interview with the Registered Dietitian confirmed that no Request for Dietary Consult had been received related to a weight change for resident #002 who was previously identified to be at high nutritional risk.

The licensee failed to ensure that their policy on Weight and Height Monitoring was complied with. [s. 8. (1) (a),s. 8. (1) (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 ensuring that the home's policy on Weight and Height Monitoring is complied with, to be implemented voluntarily.

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident #002 was identified by the Substitute Decision Maker (SDM) to prefer to remain in bed until after breakfast daily.

Interview with Personal Support Workers (PSW) on April 15 and 16, 2014 confirmed that messages had been left by the SDM to allow resident #002 to remain in bed. The PSW's identified that this change in the resident's care should be identified in the plan of care and had been communicated to staff by the SDM.

The plan of care was reviewed in the company of the Registered Practical Nurse and the Resident Assessment Instrument, Quality Improvement Coordinator (RAI QI). The plan of care indicated under bed mobility that resident #002 preferred to rise between 0730 - 0800 hours.

The plan of care for resident #002 was not revised to include the SDM's request for resident #002 to remain in bed until after breakfast. [s. 6. (10) (b)]

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Issued on this 23rd day of April, 2014

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

Debora Saville (192)