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
Nov 18, 2013	2013_241502_0003	T-623-13	Critical Incident System

Licensee/Titulaire de permis

BARRIE LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

ROBERTA PLACE
503 ESSA ROAD, BARRIE, ON, L4N-9E4

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

JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 5, 6, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), dietary aide (DA), and resident's family member

During the course of the inspection, the inspector(s) observed meal service, reviewed resident health records, relevant policies and procedures, master diet list (MDL) and the home's investigation

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a process in place to ensure personal support workers assisting residents in the dining room are kept aware of the residents' diet needs.

Staff interviews revealed that personal support workers are not required to be aware of the resident's diet needs during the meal, but personal support workers are involved in serving the plated food and assisting residents at mealtimes.

A record review confirmed that the home did not have a process in place to ensure that all staff assisting residents during mealtimes are aware of the residents' diet needs. On an identified date, Resident #1 required a minced textured plated food at dinner. A personal support worker served him/her a regular textured plate of food, Resident #1 choked, aspirated and died. The coroner's report identified airway obstruction as the immediate cause of death [s. 73. (1) 5.]

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 food service workers, and other staff assisting residents are aware of the residents' diet, special needs and preferences, 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. (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 saillants :

1. The licensee failed to ensure that the care set out in the plan of care for Resident #1 is provided to Resident #1 as specified in the plan.

Resident #1's plan of care indicates that the most current diet was a minced texture diet. A record review revealed that Resident #1 was not served a minced texture diet as indicated in the plan of care.

Staff interviews confirmed that Resident #1 was served a regular texture meal at dinner on an identified date, which is not the minced texture indicated in the Resident #1 plan of care. Resident #1 choked during dinner, aspirated and died. The coroner's report identified airway obstruction as the immediate cause of death [s. 6. (7)]

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:

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 staff complied with the policies and procedures put in place related to nutrition care and dietary services and hydration.

A review of the home's policy and procedure "multidisciplinary dining room policy" dated October 7, 2013, states that all staff are required to be aware of the resident's needs in the area of nutrition; the food service staff will portion the meal and the health care provider shall serve the meal referring to the master diet list (MDL), and provide a meal that is in keeping with the resident noted likes and dislikes.

Staff interviews revealed that personal support workers are not required to be aware of the resident's diet needs during meal services, they are not referring to the master diet list while serving the meal to residents, and it is primarily the dietary aide's responsibility to be aware of the resident's diet. Staff also confirmed that personal support workers involved in ordering and serving Resident #1 dinner were not aware that his/her diet was changed to full minced texture, and they did not refer to the master diet list while serving Resident #1 dinner meal as per the home's policy.

A review of the resident "cardex policy and procedures" dated April 2, 2009, section meal service of the nutrition manual, indicates that food service staff must check each resident's cardex grouped by table numbers throughout the proper order of meal service.

Staff interviews confirmed that the dietary aide involved in portioning the resident dinner meal did not refer to the master diet list during dinner meal service on an identified date, which resulted in Resident #1 choking, aspirating, and dying.
An interview with the Director of Care revealed that this incident could have been prevented if personal support workers and dietary aide viewed simultaneously the diet list as they would have known that Resident #1 was on a minced diet [s. 8. (1)]

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Issued on this 18th day of November, 2013

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