Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 18 and 19, 2010	2010_148_2534_10Aug115206 Log #00007	Other (Critical Incident) Log # O-000077

Licensee/Titulaire
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Long-Term Care Home/Foyer de soins de longue durée
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Phone (905)576-5181 Fax 576-0078

Name of Inspector(s)/Nom de l'inspecteur(s)
Amanda Nixon (ID #148)

Delores MacDonald (ID #136)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to the choking incident of an identified resident. Critical incident # 2534 000040 10, was submitted to the MOHLTC by the home July 6, 2010.

During the course of the inspection, the inspectors spoke with members of the management team including the Administrator, Director and Associate Director of Care, Resident Assessment Instrument (RAI) coordinator, Food Service Manager, the home's Registered Dietitian, Registered Nurse Carolyn and Registered Practical Nurse Stephanie responsible for care August 18, 2010 on Rose Garden, personal support worker D. Harrington and residents on the Rose Garden unit. In addition, the inspectors spoke with two corporate representatives including Karen Jones, Corporate Manager of Clinical Services and Marilynn Gordon Regional Manager, who was providing coverage in the administrator's absence August 19, 2010.

During the course of the inspection, the inspectors reviewed the resident's health record and observed the supper meal August 18, 2010 and breakfast meal August 19, 2010.

The following Inspection Protocol was used: Nutrition and Hydration Inspection Protocol

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective

Findings:

1. The current physician order for an identified resident states that ht/she is to be provided Glucerna supplement when a meal is refused. The Nutritional Status Resident Assessment Protocol (RAP), June 25, 2010, stated that the resident refuses supplements as he/she believes them to cause bowel movements. The plan of care does not reflect this issue.

2. The plan of care for an identified resident indicates that he/she is to be provided meals in the main dining room. The Registered Nurse, Registered Practical Nurse and Personal Support Worker responsible for care August 18, 2010, on Rose Garden, report that the resident frequently ate supper meals in the Rose Garden lounge due to behaviors. The plan of care does not reflect the resident's needs.

3. The Registered Nurse, Registered Practical Nurse and personal support worker responsible for care August 18, 2010 on Rose Garden and the Registered Dietitian reported that the resident was known to have a choking risk previous to the choking incident, related to eating too quickly and talking with his/her mouth full of food. The plan of care, dated June 29, 2010, does not indicate the risk of choke and there are no interventions related to the resident eating too quickly.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8, 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.

Findings:

1. The plan of care for an identified resident states that he/she is to be brought into the dining room, after the meal has been place at the table, due to the resident becoming verbally and/or physically disruptive at meal time. This service was not provided at the supper meal, on August 18, 2010, nor at the breakfast meal, on August 19, 2010. The resident became verbally disruptive waiting for the meal to be served on August 18, 2010.

2. The plan of care for an identified resident states that he/she is to be provided her meals in the main dining room. The critical incident submitted by the home and the multidisciplinary progress notes indicate that the resident was provided his/her supper meal in the Rose Garden lounge on the date of the choking incident.

3. The plan of care states that resident is to have a Speech Language Pathologist (SLP) referral completed, related to a choking incident. The referral was initiated July 5, 2010, the physician signed the referral July 14, 2010. As of August 18, 2010 the referral form had not been faxed and there had been no staff follow up. A Registered Practical Nurse, faxed the SLP referral form August 19, 2010 after LTCH Inspector questioned the lapse of time.

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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 process for SLP referral and assessment is completed in a timely manner, to be implemented voluntarily.

WN #3 The Licensee has failed to comply with O. Reg. 79/10, s. 59

Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(b) occupational therapy and speech-language therapy.

Findings:

1. An identified resident had a choking incident. A referral to the SLP was initiated by a Registered Practical Nurse on July 5, 2010 but was not faxed for processing until August 19, 2010. An assessment completed by the registered dietitian on July 9, 2010, recommended an SLP assessment. As of August 19, 2010, the resident had not been assessed by the SLP, as per recommendations.

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Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la

	responsabilisation et de la performance du système de santé. Deloree MacDonald
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).