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
Oct 17, 2013	2013_200148_0040	O-000923-13	Complaint

Licensee/Titulaire de permis

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD, METCALFE, ON, K0A-2P0

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

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD, METCALFE, ON, K0A-2P0

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

AMANDA NIXON (148)

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): October 11 and 15, 2013, on site.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Unit Clerk, Nutritional Manager, Registered Nursing Staff, Personal Support Workers (PSW), Food Service Workers, Volunteer, Hired Sitter and residents.

During the course of the inspection, the inspector(s) reviewed resident health care records including the plans of care, flow sheets and assessments, diet lists and the nursing staff schedule report for the period of September 22 to October 5, 2013. In addition, the inspector observed resident care and a meal service on October 11 and 15, 2013.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 comply with LTCHA 2007, S.O. 2007, c.8, s.6(2), whereby the licensee did not ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Resident #1 was observed at the supper meal on October 15, 2013. The resident was provided the main course at 1716 hours, at which time encouragement was provided by a PSW; the resident attempted to feed self without success. The PSW later returned to cut up the resident's food at 1721 hours, after which the resident was observed to have difficulty spooning food to mouth. The resident was then provided physical feeding assistance intermittently between 1727 and 1735 hours. At 1735 a PSW provided total physical feeding assistance for the remainder of the meal, until 1747 hours. The resident was receptive to the assistance and ate well. At 1747 hours, dessert was provided to Resident #1, the resident was not observed to feed self. A PSW provided physical feeding assistance with dessert at 1751 hours, the resident was receptive and ate well.

Resident #1 was observed at the lunch meal on October 11, 2013. Resident #1 was seated at a table with 3 other residents and 2 staff members, who were providing various levels of feeding assistance to the residents. Resident #1 was observed to be provided constant encouragement and/or physical assistance throughout the meal.

The plan of care for Resident #1 indicates the resident is to receive texture modification and feeding assistance, described as: visual cueing and set up. The plan of care also included that the resident may need to be fed and will require repeated encouragement.

The resident's plan of care is not based on the feeding needs of the resident, as observed on October 11 and October 15, 2013.

Resident #4 was observed at the lunch meal on October 11, 2013. The resident was provided the main meal at 1221 hours. Between 1221 and 1235 hours the resident was observed to be distracted and was not focused on the task of eating. A staff member approached at 1235 hours and provided encouragement with fluids only. Staff were observed on one occasion during the meal service to provide verbal encouragement with the meal. The resident was observed to only take a few bites of food independently, during the meal service. The meal was removed from the

resident, with less than 25% consumed.

Resident #4 was observed at the supper meal on October 15, 2013. The resident was provided the main course at 1709 hours and was observed to attempt to spoon food to mouth but was unsuccessful. At 1713 hours the RPN approached the resident and placed a half sandwich, from the resident's plate, into the resident's hand. The resident was able to consume the sandwich independently. Between 1713 and 1745 hours, staff members were observed to approach the resident but did not provide feeding assistance or encouragement. During the same time the resident was observed to be distracted and was not observed to feed self. At 1745 hours a PSW approached, asked the resident if they were done and if the resident wanted dessert. The resident agreed and the staff member removed the plate and provided the resident with dessert. A PSW staff member approached the resident at 1755 hours, and provided verbal encouragement. The resident consumed less than half of the dessert.

Resident #4 is care planned to receive set up assistance including, food cut up and encouragement of finger foods.

The plan of care for Resident #4 is not based on the feeding needs of the resident, as observed October 11 and 15, 2013. [s. 6. (2)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (7), whereby the licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The current plan of care related to eating, for Resident #2, indicates that the resident is to be provided encouragement and that the resident can feed self most of the time but may require feeding assistance; staff are to monitor the need for assistance as the resident may fall asleep during meals.

Resident #2 was observed at the lunch meal service on October 11, 2013. The resident was provided the main course at 1229 hours. The resident was observed to be lethargic throughout the meal service and did not attempt to feed self, no staff members were observed to encourage or provide feeding assistance. At 1300 hours, a staff member removed the plate from the resident; no attempt was made at this time to provide feeding assistance. The staff member returned with dessert and provided

total physical feeding assistance; the resident was receptive to the assistance and ate the dessert well.

Resident #2 was not provided with the feeding assistance as set out in the plan of care as it relates to the need to provide feeding assistance. [s. 6. (7)]

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 the plan of care is based on the needs of the resident and is provided as set out in the plan of care, to be implemented voluntarily.

Issued on this 17th day of October, 2013

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