



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 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
Direction de l'amélioration de la performance et de la conformité

HAMILTON Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11ième étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Dec 7, 8, 12, 21, 29, 2011; Jan 6, 2012 | 2011_067171_0029 | Follow up

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

VERA M. DAVIS COMMUNITY CARE CENTRE
80 Allan Drive, Bolton, ON, L7E-1P7

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

ELISA WILSON (171)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, food services manager, the RAI coordinator, registered dietitian, cook, dietary aides, registered staff, personal support workers, and residents.

During the course of the inspection, the inspector(s) observed two meal services, taste tested pureed menu items at lunch and regular menu items at dinner, and reviewed production sheets, recipes and serving sizes. The inspector reviewed the residents' council minutes and interviewed 11 residents regarding food quality. The inspector reviewed the plans of care for three identified residents regarding nutrition care.

H-002051-11

The following Inspection Protocols were used during this inspection:

- Dining Observation
Food Quality
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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.)

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The plan of care was not based on an assessment of the resident's needs regarding positioning at the dining table for an identified resident. The resident was assessed to be independent with eating, however required some encouragement to finish. According to the food/fluid intake records the resident has had a poor intake at lunch and dinner for the past two months. There was no assessment or care planning related to positioning and how that may relate to intake or whether an increased level of assistance is required. There was no indication in the plan of care that other positioning options had been attempted or assessed to meet the needs and preferences of the resident when dining.

Issued on this 11th day of January, 2012

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

Elisha Wilson